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No.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.

Petitioner,

vs.

WALTER L. REAZIN, M.D., et al.

Respondents.

APPENDIX VOLUME III TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

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Fed.R.Civ.P. 56(c) provides that summary judgment "shall be rendered forthwith" if the record shows "that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law." The plain language of Rule 56(c) "mandates the entry of summary judgment" against any party "who fails to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Celotex Corp. v. Catrett*, 477 U.S. , 91 L.Ed.2d 265, 273, 106 S.Ct. 2548, 2552-53 (1986). The Court explained this holding in the following terms:

> In such a situation, there can be "no genuine issue as to any material fact," since a complete failure of proof concerning an essential element of the nonmoving party's case necessarily renders all other facts immaterial. The moving party is "entitled to judgment as a matter of law" because the nonmoving party has failed to make a sufficient showing on an essential element of [its] case with respect to which [it] has the burden of proof.

Celotex, 91 L.Ed.2d at 273, 106 S.Ct. at 2553.

Thus, a claimant must present affirmative evidence as to each essential element of its claim to defeat a properly supported motion for summary judgment. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. , 91 L.Ed.2d 202, 217, 106 S.Ct. 2505, 2514

(1986). The mere existence of a scintilla of evidence in support of plaintiff's position is insufficient; there must be evidence on which a jury could reasonably find for the plaintiff. *Liberty Lobby*, 91 L.Ed.2d at 213-14, 106 S.Ct. at 2512.

Neither the fact that the counterclaim raises claims under the antitrust laws, nor my previous denial of defendant's motion for summary judgment on plaintiffs' complaint precludes summary disposition of its counterclaim. The Supreme Court expressly rejected the first proposition in *First Nat'l Bank v. Cities Service Co.*, 391 U.S. 253, 289-90 (1968):

> To the extent that petitioner's . . . argument can be interpreted to suggest that [Rule 56] should, in effect, be read out of antitrust cases and permit plaintiffs to get to a jury on the basis of the allegations in their complaints, coupled with the hope that something can be developed at trial in the way of evidence to support these allegations, we decline to accept it. While we recognize the importance of preserving litigants' rights to a trial on their claims, we are not prepared to extend those rights to the point of requiring that anyone who files an antitrust complaint . . . be entitled to a full-dress trial notwithstanding the absence of any significant probative evidence tending to support the complaint.

See also Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. , 89 L.Ed.2d 538, 106 S.Ct. 1348 (1986); *Instructional Sys. Dev. Corp. v. Aetna Cas. & Surety Co.*, No. 82-2105, slip op. at 8-9 (10th Cir. Apr. 22, 1987).

The second proposition is equally unsound. In essence, defendant claims that "consistency" alone requires the denial of the present motion for summary judgment: "Simply stated, this Court cannot grant summary judgment against the Blue Cross counterclaim and be consistent with its prior decision denying the Blue Cross motion for summary judgment against the main claim." (Dkt. 266, Memo. in Opp. to Pltfs.' Motion for Summ. Judg. on Ctrclm., p. 121; *see also* pp. 2-3, 119, 156.) Summary judgment jurisprudence has never been based on such simplistic notions of "fairness", i.e., "you gave *them* a trial, now you have to give *us* one also!" Rather, true "consistency" requires careful application of established principles of law to the counterclaim, to determine whether BCBSK and HMOK have advanced significant probative evidence demonstrating the existence of genuine issues of material fact as to each of their claims.

A party resisting a motion for summary judgment must do more than make conclusory allegations; it "must set forth specific facts showing that there is a genuine issue for trial." *Dart Industries, Inc. v. Plunkett Co. of Okla.*, 704 F.2d

496, 498 (10th Cir. 1983). To be considered "genuine", a material issue must be established by sufficient evidence supporting the claimed factual dispute to require a jury or judge to resolve the parties' differing versions of truth at trial. *White v. Hearst Corp.*, 669 F.2d 14, 18 (1st Cir. 1982); *see also Durasteel Co. v. Great Lakes Steel Corp.*, 205 F.2d 438, 441 (8th Cir. 1953) ("An issue of fact is not genuine unless it has legal probative force as to a controlling issue.").

Under Rule 56, a party opposing summary judgment must establish the existence of an issue of fact which is *both* "genuine" *and* "material". A "material" issue is one which affects the outcome of the litigation. *White*, 669 F.2d at 18. A factual issue that is not necessary to that decision is not material within the meaning of Rule 56(c), and a motion for summary judgment may be granted without regard to whether it is in dispute. *Cox v. Bell Helicopter Internat'l*, 425 F.Supp. 99, 102 (N.D. Tex. 1977) (quoting 10 Wright & Miller, Federal Practice & Procedure: Civil §2725).

In assessing whether a party opposing summary judgment has raised a "genuine issue of material fact," the court may only consider evidence that would be admissible at trial. *World of Sleep, Inc. v. La-Z-Boy Chair Co.*, 756 F.2d 1467, 1474 (10th Cir.), *cert. denied* 106 S.Ct. 77 (1985). The party opposing summary judgment must do more than simply show that there is some "metaphysical doubt"

as to the material facts. *Matsushita*, 106 S.Ct. at 1357. Rather, it must adduce evidence that is "significantly probative" of the disputed fact. *Neely v. St. Paul Fire & Marine Ins. Co.*, 584 F.2d 341, 344 (9th Cir. 1978) (citing *First Nat'l Bank v. Cities Service Co.*, 391 U.S. 253, 288-90 (1968)). Where the record as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no "genuine issue for trial." *Matsushita*, 106 S.Ct. at 1356.

It is clear now the counterclaim was a defensive ploy, a maneuver, probably suggested and instigated by defense counsel, to divert attention from plaintiffs' complaint. Even after the counterclaim was filed, the principal responsible BCBSK executives, including its president, Wayne Johnston, the senior vice president for external affairs, Marlon Dauner, and the vice president of marketing and alternative delivery systems and chief executive officer and executive director of HMOK, John Knack, testified they were unaware of any facts tending to support the counterclaim. (Johnston Depo., pp. 293-94; Dauner Depo., pp. 95-98; Knack Depo., pp. 131-32.) Elsewhere, one of BCBSK's lawyers forthrightly acknowledges he "alone, was responsible for drafting Blue Cross' answer to the complaint and Blue Cross' counterclaim in this matter," and he estimates "my . . . time expended for these tasks [was] no more than 10 hours." (Dkt. 267, Memo. in Opp. to Pltfs.' App. for Attys'. Fees & Bill

of Costs, p. 17, and attached Aff. of Daniel R. Shulman, ¶5.) I wholeheartedly agree with defendant's representation to the Tenth Circuit Court of Appeals that this jury and I heard "all the evidence" related to the counterclaim. The 6-week trial of "plaintiffs' complaint" was focused largely on BCBSK's counterclaim as its "rule of reason defense." With the benefit of that trial evidence, time, and my study of the parties' memoranda on the motion for summary judgment, I am now inclined to agree with the BCBSK officials' assessment.

Thus, I address the motion for summary judgment on the counterclaim in the extraordinary posture of having received the documentary evidence and having heard, firsthand, the live testimony of the witnesses. Much of that evidence and testimony was set forth at the outset of this opinion. In these unique and unusual circumstances, having tried the counterclaim in everything but its name, I grant counterclaim defendants' motion for summary judgment.

The counterclaim defendants have prepared and submitted a well-researched memorandum containing proposed findings of fact and conclusions of law. I adopt both, and, with some repetition of facts in the interest of clarity, find as follows:

Facts.

-- Health Care Plus --

1. HCP was formed in October, 1977, under the name of Community Health Care Association. (Tran. 17, p. 2930.) Its founder, Garland Bugg, was then employed at the Wichita Clinic, a multi-specialty physician group practice located in Wichita. (*Id.* p. 2925.) At the Wichita Clinic, Mr. Bugg was responsible for the development and administration of the Wichita Clinic health plan, which on January 1, 1974, became the first state-certified HMO in Kansas. (*Id.*, pp. 2925-27.)

2. Participation in the Wichita Clinic HMO was limited to physicians at the clinic, but the experiment generated community-wide interest among other Wichita physicians. (*Id.*, p. 2927.) In January of 1977, the Wichita Clinic discontinued its own HMO activities. (*Id.*) Mr. Bugg left the Wichita Clinic one year later to work full-time in developing Community Health Care Association, a nonprofit HMO formed in the fall of 1977 in response to the interest expressed by physicians throughout Wichita in participating in a prepaid medical plan. *Id.*, pp. 2927-28.)

3. On July 1, 1981, Community Health Care Association received federal qualification and changed its name to Health Care Plus. (Tran. 17, p. 2931.) By obtaining federal qualification, HCP achieved the ability to "mandate" employers, that is,

to require employers to offer an HMO option in their employee health insurance benefits. (Tran. 4, pp. 531-32.) An employer is not required to offer more than one federally qualified HMO option of the same type to its employees. However, if another federally qualified HMO approaches an employer with an HMO option different in structure and benefit design, that HMO also can require the employer to offer this second HMO option to its employees. (Tran. 4, p. 532; Tran. 12, pp. 2022-23.)

4. When it obtained federal qualification, HCP was the only HMO in Sedgwick County, which conferred distinct marketing advantages upon HCP. (Tran. 4, pp. 533-34; Tran. 27, pp. 4491-92, 4513-14.) With federal qualification HCP was able to mandate employers beginning in July, 1981. This allowed HCP to establish an HMO enrollment base, a factor of critical importance in HMO development. (Tran. 6, p. 1038; Tran. 7, pp. 1104-05; Tran. 16, pp. 2691-92; Tran. 21, pp. 3411-12; Def's. Ex. 553.) HCP worked hard to take full advantage of its priority in the marketplace, employing between four to six marketing representatives in Sedgwick County. (Tran. 17, pp. 2932-33.) By 1983, it had enrolled approximately 13,000 members (*Id.*) and had established itself as one of the first successful HMOs in Kansas. (Tran. 4, p. 531.)

5. In addition, HCP established good relationships with its contracting providers during this period, which also contributed to its long-term success. (Tran. 17, p. 2932.) Because HCP was

successful enrolling subscribers, medical groups which were initially unenthusiastic about prepaid medical plans ultimately signed on with HCP to prevent erosion of their patient base. (Tran. 16, pp. 2689-90.) HCP's success enrolling members provided its contracting physicians with increasing patient bases and attractive compensation arrangements. (Tran. 16, p. 2695; Tran. 26, p. 4195-97.)

6. HCP's contracts with medical groups are capitation contracts, under which physicians are paid a set fee per month for each HCP member choosing that physician as his or her primary care physician. (See Tran. 17, pp. 2978-79.) Capitation contracts are a prepayment mechanism which involved an element of "risk bearing" in the sense the provider bears part of the insurance risk under the arrangement. (Tran. 7, pp. 1246, 1257, 1259; Tran. 17, pp. 2979-81.) The provider receives a set capitation amount per member per month regardless of actual utilization by his or her patients. If no patients require medical attention in a given month, it results in a financial benefit to the provider, who has been "paid" despite the fact no services were performed. On the other hand, a serious illness might quickly deplete the entire capitation payment fund since the contracting physician is required to finance his own services as well as those of any referral specialists out of that fund. (Tran. 16, pp. 2691-95; Tran. 17, pp. 2979-83.)

7. Capitation arrangements work well for a primary care physician if there are a large number of individuals who are enrolled in the program. The

concept behind paying so much per member per month is that the physician will receive payment on every individual patient who is enrolled in the program even if they do not receive care. If there are very few patients enrolled in the program, the services the primary care physician provides would not be covered by the amount of income he receives through his capitation payment. (Tran. 7, p. 1104.)

8. In addition, an adequate level of enrollment is essential to protect the primary care physician from an unacceptable level of risk by participating in the program. If enrollment is low, there is an insufficient "risk pool" to protect the physician from significant financial loss in the event one of his HMO patients requires intensive medical treatment. (Tran. 16, pp. 2691-95, 2701-02; Tran. 26, pp. 4197-98.)

9. In 1983 HCP decided to expand its operations to areas outside Sedgwick County. It planned to expand initially to Lawrence and Topeka, and then to other cities in Kansas. HCP anticipated this initial expansion would require approximately $2 million, and it decided to raise capital by converting to for profit status and issuing stock to investors pursuant to a private placement. (Tran. 17, pp. 2933-34, 2964-65.)

10. The HCP stock offering was formally made pursuant to a prospectus issued in march, 1984. (Tran. 16, p. 2708.) Stock was offered at $1.00 per share to certain physicians who were under contract with HCP as providers, in particular to those

physicians who had been strong supporters of HCP. (Tran. 17, p. 2936; Tran. 25, p. 4095.) Stock was also offered to certain other physicians who were *not* under contract with HCP, as well as to other private investors in Wichita. (Tran. 17, pp. 2940-41; Tran. 25, p. 4095.) Investors who elected to purchase HCP stock were required to make their decisions and advance the requisite funds in early 1984. (Tran. 27, pp. 4372, 4382.) The stock was actually issued the following August. (Tran. 16, p. 2719; Tran. 26, p. 4183; Tran. 29, p. 4749.)

11. HCP's principal reason for offering stock to physicians and others was to raise capital to fund its planned expansion of operations. (Tran. 17, pp. 2936, 2964-65.) HCP also perceived equity involvement by physicians as a means of solidifying its relationship with providers and fostering physician involvement in the HCP program. (Tran. 17, p. 2937; Tran. 25, pp. 3986-87; Tran. 26, p. 4237.) However, HCP placed no conditions on the availability of its stock that the physician must do business "exclusively" with HCP or refrain from doing business with any other HMO. (Tran. 17, p. 2938; Tran. 25, pp. 3977-80.)

12. In 1984, there were approximately 250 primary care physicians in Wichita. (Tran. 17, p. 2939; Tran. 26, p. 4233.) Nineteen primary care physicians, excluding the primary care physicians at the Wichita Clinic, ultimately became HCP shareholders. (Tran. 17, p. 2940.) The Wichita Clinic purchased 100,000 shares of HCP stock as a

group through a subsidiary corporation, The Wichita Clinic Building Company, Inc. (Tran. 17, p. 2940; Tran. 26, p. 4151.) In 1984 there were approximately 80 physicians at the Wichita Clinic, approximately 20 of whom were primary care physicians. (Tran. 26, p. 4203.)

13. The Wichita Clinic was one of the groups which had been under contract with HCP since its inception. (Tran. 25, pp. 3984-85, 3987.) The Wichita Clinic's purchase of HCP stock was approved by the Clinic's Executive Committee after substantial discussion on March 19, 1984, by a vote of 4 to 3. (Tran. 26, pp. 4148, 4151; BC Ex. 452.)

14. HCP also offered stock to Hillside Medical office, Dr. Reazin's group practice, in March of 1984. (Tran. 16, p. 2708.) At that time, five physicians were associated with Hillside Medical Office. (Tran. 16, p. 2665.) The office declined to purchase HCP stock as a group. (Tran. 16, p. 2708.) Subsequently, Dr. Conrad Osborne, one of Dr. Reazin's partners, purchased HCP stock individually. (Tran. 16, p. 2709; Tran. 27, p. 4372.) Thereafter, Dr. Reazin also purchased a block of HCP shares. (Tran. 16, p. 2709.) Dr. Reazin decided to purchase HCP stock as an investment, a decision which was unrelated to his medical practice. (Tran. 16, p. 2710.) Dr. Reazin's purchase of HCP stock was not conditioned upon any commitment that Hillside Medical Office would only do business with HCP. (Tran. 25, p. 4102.)

-- Competition --

15. Throughout its history, HCP has faced intense competition in the private health care financing market. (Tran. 25, pp. 4115-16.) This market includes traditional indemnity insurance products, HMOs, PPOs, and self-insured programs. (Tran. 6, p. 1013; Tran. 25, pp. 4115-16; Tran. 28, p. 4565.) There are approximately 200 companies offering traditional indemnity insurance products in Kansas. (Tran. 6, p. 1013.) The largest of these is BCBSK, which is also the largest provider of private health care financing in Sedgwick County. (Stip. j.)

16. Approximately 37% of the total population in Kansas has Blue Cross insurance coverage. (Tran. 21, p. 3394.) BCBSK therefore has between 47% and 60% of the total insurable population in Kansas. (Tran. 21, pp. 3393, 3395-96; Pltfs.' Ex. 41.) Based on premium dollars, BCBSK has 62% of the private health care financing market in Kansas. (Tran. 9, p. 1476.) Its next largest competitors, Bankers Life and Aetna, have 4% and 3%, respectively. (*Id.*)

17. All but one hospital in Kansas (Memorial Hospital in Topeka) are contracting hospitals with BCBSK under its CAP program, BCBSK's traditional indemnity insurance program. (Tran. 4, pp. 558-59.) Ninety percent of all physicians in Kansas are contracting CAP providers. (*Id.*, p. 559.) Under these contracts, BCBSK is able to invoke the "most favored nations clause", pursuant to which BCBSK is entitled to the lowest prices for medical services

which a contracting provider makes available to any other health care financing organization. (Tran. 4, p. 600; Pltfs.' Ex. 112.)

18. BCBSK reimburses CAP providers on the basis of "maximum allowable payments", which are set unilaterally by BCBSK each year. (Tran. 5, p. 717; Tran. 6, pp. 943-46; Tran. 12, p. 2068.) Since BCBSK is the largest source of private revenues to its contracting providers, it is able to command considerable discounts from its providers' normal charges for medical services. (Tran. 9, pp. 1448-49, 1459-60; Tran. 1, pp. 26-27; Tran. 15, pp. 2639-40.)

19. HMOs also compete with PPOs in providing private health care financing. (Tran. 6, p. 1013.) Several PPOs are doing business in Wichita in direct competition with HCP. (Tran. 25, p. 4115.) Recent PPO entrants in Wichita include Aetna (Tran. 28, p. 4558) and two new PPOs formed by the Sedgwick County Medical Society and St. Francis Regional Medical Center. (Tran. 7, pp. 1104-05; Tran. 26, pp. 4152-53, 4193; Def.'s Ex. 553.)

20. A large number of companies in Wichita also provide health care financing benefits to their employees through self insurance. Approximately 100,000 persons in greater Wichita, or roughly one-third of the total population, are covered by self-insured programs. (Tran. 28, pp. 4728-31.) These programs also compete against traditional indemnity insurance products, HMOs and PPOs. (Tran. 28, p. 4565.)

21. Despite its progress, these alternative

products and programs placed competitive limitations on HCP's growth in the Wichita marketplace. In 1985, for example, HCP only had between 8% and 12% of the private health care financing market in greater Sedgwick County. (Tran. 25, pp. 4041-42.)

-- HMO Kansas --

22. BCBSK, the largest private health care financing organization in Kansas, established and maintained its preeminent position through its traditional indemnity insurance product. (Tran. 4, pp. 534-35.) BCBSK currently offers HMO products through HMO Kansas, Inc. ("HMOK"), a wholly-owned subsidiary. (Stip. h.) BCBSK's HMO effort is a relatively recent development, as BCBSK was slow in developing alternative delivery systems such as HMOs and PPOs. (Tran. 4, p. 574.)

23. In July of 1983, HMOK announced plans to enter Wichita and other parts of Kansas with an HMO product offering. (Tran. 6, pp. 1023-24.) HMOK received state certification in February, 1984, enabling it to commence marketing operations. (*Id.*, pp. 1036-37.) As of that time, HMOK had secured contracts with 73 primary care physicians and 201 specialists in Wichita in anticipation of beginning marketing operations. (*Id.*, pp. 1037-38; Def.'s Ex. 536.) Thirty-three primary care physicians and 103 specialists in Topeka had entered into contracts with HMOK at that time. (*Id.*) By July of 1984, HMOK

had executed contracts with more than 100 primary care physicians in Wichita. (Knack Depo., pp. 115-16.)

24. HCP was already well established in Wichita by the time HMOK entered the market, having begun operations in Sedgwick County some three years earlier. (Tran. 12, p. 2027.) When HMOK began marketing in Wichita, HCP already had approximately 35,000 members in Sedgwick County. (*Id.*) BCBSK recognized HCP's head start in Wichita would place HMOK at a considerable disadvantage. (Tran. 4, pp. 533-34, 575; Tran. 6, p. 1038.)

25. From the outset, HMOK experienced difficulty penetrating the Wichita market. (Tran. 6, p. 1079-80; Def.'s Ex. 546.) HCP's early presence in the market had allowed it to capture a significant membership base and to develop a better physician list. (*Id.*) HMOK did not receive federal qualification in Wichita until July of 1984. (Knack Depo., p. 110.) Further, it attempted to enter Wichita with the same HMO model as HCP, and offering substantially similar benefits. (Tran. 12, pp. 2027-28.) Even after receiving federal qualification, HMOK was therefore unable to mandate employers to offer the HMOK product side by side with HCP. (See Statement of Material Fact (SMF) ¶3, *supra*.) HMOK had other difficulties as well. HMOK's marketing personnel observed, for example, that HMOK had inadequate staffing and an insufficient

advertising budget. (Pltfs.' Ex. 51, at p. 6700.)

26. HMOK also experienced difficulties in recruiting and retaining physicians in Wichita. Certain groups declined to do business with HMOK from the outset. HCP had a definite advantage over HMOK because it offered higher capitation payments to physicians than the BCBSK HMO. (Tran. 8, p. 1348.) HMOK offered two different risk packages which physicians could accept: full risk and partial risk contracts. (Tran. 16, pp. 2702-03; Tran. 29, pp. 4762-63.) If a physician was under contract with HCP, however, HMOK required that physician to sign the full risk contract. (Tran. 29, pp. 4762-63.) Certain doctors objected to this requirement and declined to participate in the HMOK program on this basis. (*Id.*)

27. Doctors were also dissatisfied with other aspects of the HMOK program. Family Physicians, P.A., for example, a Wichita family practice group, decided not to contract with HMOK in the summer of 1983 (Tran. 26, pp. 4261-62) because HMOK's program involved participating in a community risk pool which placed Family Physicians at risk based on the performance of medical groups over which Family Physicians had no control in terms of quality assurance and cost effectiveness. (Tran. 26, p. 4283.) HMOK's low enrollment and inferior coverage were also factors in Family Physicians' decision not to participate in the Blue Cross HMO. (Tran. 26, pp. 4282-84.) Other reasons why certain physicians declined to contract with HMOK included lingering

philosophical reservations about prepaid medical plans generally, and general disenchantment with BCBSK. (Tran. 29, pp. 4762-63.)

28. Nevertheless, a substantial number of primary care physicians and specialists in Wichita did enter into contracts with HMOK in late 1983 and early 1984 (see SMF ¶23, *supra*), including Hillside Medical Office and the Wichita Clinic. (Tran. 16, p. 2688; Tran. 26, p. 4145.) Hillside Medical Office signed its contract with HMOK in October of November of 1983; the contract had an effective date of march, 1984. (Tran. 16, p. 2688.) The Wichita Clinic also decided to participate with HMOK in late 1983. (Tran. 26, p. 4145.) Both Hillside Medical Office and the Wichita Clinic were under contract with HCP when they entered into contracts with HMOK. (Tran. 16, pp. 2688, 2706; Tran. 26, pp. 4144-45.)

29. Despite HMOK's initial success in securing contracts with primary care physicians and specialists in Wichita, it was unable to develop an adequate membership base in Sedgwick County. By July of 1984, HMOK had enrolled only 1800 members in Wichita. (Knack Depo., pp. 115-16.) By the end of 1984, its Wichita enrollment totaled just 2,000 members. (Tran. 12, p. 2027.) HCP, by comparison, had approximately 35,000 members in 1984. (Tran. 17, p. 3025; Pltfs.' Ex. 65 at p. 9.)

30. By mid-1984, HMOK recognized it was having difficulty penetrating the Wichita area, particularly in view of HCP's established

"predominance". (Def.'s Ex. 546 at p. 3.) This difficulty was attributed to the fact HCP was in Wichita prior to HMOK, resulting in predominant enrollment numbers and a better Physician list. (Tran. 6, pp. 1079-80.)

31. On September 5, 1984, the HMOK board of directors decided to discontinue HMOK's activities in Sedgwick County. (Def.'s Ex. 553.) The minutes of that board meeting explained the reasons for that decision as follows:

> Mr. Knack, at the request of Mr. Barnes, reported that activity in Wichita was not as promising as in other areas. The Wichita Clinic and the Hillside Clinic are both dropping or have dropped from the primary care physician lists of HMO Kansas. Since the HMO Kansas product is highly similar to that of Health Care Plus, and since the prices are competitive for both organizations, the only real arena for competition is in the physicians list. With Wichita and other large clinics affiliated with it, Health Care Plus has a definite and probably insurmountable marketing edge in Wichita. This marketing edge results in HMO Kansas not being able to enroll many persons. The lack of a volume of enrollment through employer groups results in the physicians who continue to participate with HMO Kansas having too few patients to provide them with a manageable risk. That is, with only a few patients, the capitation

allowances are not large enough to provide physicians with a margin of safety against very ill cases among HMO enrollees. This causes physicians to continue to be tempted to drop out of the program and to have dissatisfaction with the program[;] even if they remain in, they incur losses or do not experience any distribution of surplus. The product, Mr. Knack reported, appears less and less marketable in Wichita because of this, and because of some impending actions of Blue Cross and Blue Shield. Preferred provider organizations are gaining a foothold in Wichita, with both the Sedgwick County Medical Society and St. Francis announcing the development of PPOs. In addition, there is a rumor that Health Care Plus is about to establish a PPO. In response, Blue Cross and Blue Shield intends to establish a form of PPO, with highly competitive reimbursement levels and rates, which will tend to eat into the pricing advantage of HMOs. While there are some adverse effects from HMO Kansas ceasing operations in Wichita, Mr. Knack indicated it was staff's consensus that such was a proper step to take. That is, rather than continue to shuttle patients from one physician to another, and rather than see the program, and relationships with providers, destroyed by increasingly bad risks being taken by providers and severely limited enrollment opportunities causing a loss of morale in staff,

> staff recommends that the program in Sedgwick County be terminated.

(Def.'s Ex. 553.) Marlon Dauner, BCBSK's senior vice president for external affairs, testified these minutes accurately set forth the reasons why HMOK decided to discontinue operations in Wichita. (Tran. 12, p. 2051.)

32. By letter dated March 27, 1985, HMOK notified its Wichita area primary care physicians of its decision to cease marketing activities in Sedgwick County; that decision was explained as follows:

> HMO Kansas became operational in Wichita on April 1, 1984 with a product that featured a broad base of quality-minded Primary Care Physicians. Originally our major competitor offered a few select groups of Primary Care Physicians; however, they responded to our market entry by increasing their physician base. This resulted in little product differentiation between the two Federally Qualified HMO's in the Wichita Service Area. Employer groups, many of whom were mandated by our competitor, were reluctant to offer both plans. To date, HMO Kansas has 1800 members which is not a sufficient number in the Wichita Area to make the program feasible for the Primary Care Physician.
>
> We, therefore, have ceased marketing efforts of our present model and will be moving in a new

> direction of delivering health care. HMO Kansas is currently conducting feasibility studies in alternatives to include possible group or staff models and aligning with select hospitals in the area.

(Pltfs.' Ex. 49.)

33. Two months later, on May 22, 1985, BCBSK staff explained HMOK's withdrawal from Wichita to its medical advisory committee as follows:

> In Wichita, another situation is occurring. HMO Kansas was three years late with the major competitor being Health Care Plus with about 35,000 members. HMO Kansas had about 2,000 members. These were two HMOs that were almost identical in benefits. It was highly unlikely that both programs would stay in Kansas in identical form. HMO Kansas is now phasing out of the Wichita area in its current form. The program is being revitalized in Wichita and will be either a staff or group model HMO . . . . Staff thinks this will make a difference in what an employer will offer . . . . The Plan has been approached by physicians to be employed by HMO Kansas and several physicians want to sell their offices to HMO Kansas. All of these are alternatives and they are being evaluated and are options that will have to be considered in the future.

(Pltfs.' Ex. 65 at p. 9.)

34. Garland Bugg, president of HCP, testified he was surprised when he learned about HMOK's,decision to cease marketing operations in Wichita, explaining he did not believe one year is a sufficient period in which to assess a program's prospects for success. (Tran. 17, pp. 2962-63.) Similarly, Marlon Dauner of BCBSK conceded that HMOK was a relatively new product in Wichita and that it was hard to assess its relative success or lack of success in the short period of one year. (Tran. 7, p. 1106; Tran. 8, pp. 1349-50.)

35. William Guy, a former Blue Cross executive with 37 years' experience with Blue Cross plans, including experience as the top executive of four different plans, assessed HMOK's difficulty in Wichita as follows:

> [T]he problem with HMO Kansas in Wichita is that they did not have the commitment to get an HMO here. They did not know how to deal with the doctors. They were unwilling, unbending to do anything that it would take to get the physicians in the community back of them.

(Tran. 21, p. 3453.)

-- "Exclusivity"--

36. As a general business practice, HCP has never sought exclusive contracts from its medical groups. (Tran. 17, p. 2945.) HCP's contracts with physicians in Wichita are nonexclusive in the sense that nothing in those contracts imposes any limitation on the provider's ability to contract with other HMOs, PPOs, or other health care financing programs. (Tran. 17, pp. 2957-61; Tran. 25, p. 3982; Pltfs.' Ex. 307A.) With the exception of discussing the possibility of an exclusive contract with the Wichita Clinic (see SMF ¶¶ 39-49, *infra*), HCP did not formally seek exclusive arrangements with any medical groups in Wichita. (Tran. 17, p. 2945; Tran. 25, pp. 3977-78, 3982; Tran. 26, p. 4244.) In particular, HCP never discussed exclusive arrangements with Hillside Medical Office (Tran. 16, p. 2706; Tran. 17, pp. 2961-62; Tran. 27, pp. 4382-83) or Family Physicians, P.A. (Tran. 26, p. 4261).

37. As HMOK and other competing prepaid plans began seeking to contract with providers in Wichita, HCP responded by increasing efforts to "sell" providers on the advantages of continuing to participate with HCP. (Tran. 25, pp. 3983-85.) At no time, however, did HCP tell medical groups that they could not do business with other HMOs or PPOs. (*Id.*; Tran. 26, p. 4239.)

38. Physicians under contract with HCP who declined to contract with HMOK were offered "exclusively" on HCP's provider list in the sense

those physicians were not marketed by any other HMO. (Tran. 17, pp. 2957-58.) Such groups had an "exclusive" arrangement with HCP only in the sense they were dealing with HCP alone at the time. (Tran. 25, pp. 4021-23.) However, there was no limitation on those groups' ability to contract with another HMO, PPO, or any other competing system. (Tran. 17, p. 2943.)

-- The Wichita Clinic --

39. In the summer of 1984, HCP became aware that HMOK was attempting to create a stand-alone HMO to market the Wichita Clinic on an exclusive basis. (Tran. 17, pp. 2954-55.) During 1983, before HMOK entered Wichita, HCP had discussed the possibility of an exclusive contract with the Wichita Clinic. (*Id.*, p. 2947.) The Wichita Clinic did not respond to this proposal (*id.*, pp. 2943-44; Tran. 26, pp. 4141-42), and as discussed, the Clinic subsequently entered into a contract with HMOK. (Tran. 26, pp. 4144-45.)

40. When the Wichita Clinic was approached by HMOK concerning an exclusive arrangement in the summer of 1984, HCP became concerned about the possible loss of the clinic as a contracting HCP provider. (Tran. 17, pp. 2954-55.) The Wichita Clinic was also considering possible participation in the new St. Francis Regional Medical Center PPO at that time. (Tran. 26, pp. 4152, 4172.) HCP responded to these developments by renewing

discussions concerning a possible exclusive arrangement between the Wichita Clinic and HCP. (*Id.*; Tran. 17, p. 2958; Def.'s Ex. 453.) HCP officials made a presentation on this subject to the Wichita Clinic executive committee on June 26, 1984. (Def.'s Ex. 453.) The question under consideration by the Wichita Clinic executive committee at that time was whether the clinic would participate with HCP, HMOK, or both, as well as new PPOs. (Tran. 26, p. 4172.)

41. At the June 26 meeting, it was stated HCP would prefer that the Wichita Clinic not participate in St. Francis Regional Medical Center's PPO, but that the clinic instead participate in a new HCP program, "Health Options", a plan that would not restrict the patient to a single hospital. (Tran. 26, pp. 4152-53.) It was also indicated HCP "was interested in the clinic participating exclusively with HCP with HMO's . . . and that *thie [sic] exclusive arrangement could be broken at any time if the clinic felt it was not advantageous to do so.*" (Def.'s Ex. 453; emphasis added.)

42. The Wichita Clinic subsequently joined the St. Francis PPO. (Tran. 26, pp. 4152, 4193.) On July 10, 1984, however, the executive committee of the Wichita Clinic voted to terminate its contract with HMOK and to continue its HMO participation only with HCP. (*Id.*, p. 4173-75; Def.'s Ex. 455.)

43. Dr. Lloyd Hummer, a member of the Wichita Clinic, explained the clinic's reasons for

terminating its contract with HMOK as follows:

> The reasons were several and all related to what we felt was advantageous from a business standpoint for the Wichita Clinic. The capitation for Health Care Plus patients was $20.29 per member per month. To provide essentially the same services for Blue Cross-Blue Shield would return $17.96 per patient per month. So that we would be receiving, for essentially the same work, a little over *ten percent less* in payment, so that when the numbers were run and advised the chief financial officer, at that time had all of our HMO, Health Care Plus patients switched to HMO Kansas, our monthly revenue stream would have been *$20,000 a month less*. HMO Kansas had projected rapid growth of their HMO by aggressive marketing, suggesting 6,000 patients at the end of the year. We had been participants in HMO Kansas for several months and at that time we had *a hundred and eighty-seven patients enrolled by HMO Kansas, with a monthly revenue stream of $3,300. We had ten thousand three hundred Health Care Plus patients with a monthly capitation of over $200,000*. We had also engaged the services of an outside consultant, Mr. DeMarco, to survey the overall health market in Wichita. It was additionally our consultant's advice, to whom we

paid the money, that at this time we remain exclusive with Health Care Plus primarily because of lesser return. He also made the point that the most likely source for patients for HMO Kansas would be conversion of our current patients enrolled in Health Care Plus, and if we were on the same provider list, there would be no reasons for patients to choose one or the other, and if they converted to HMO Kansas, we again would get less return for essentially the same services. So, it was a decision of dollars and cents basically. Also, with only a hundred and eighty-seven patients in a particular plan, in prepayment modes of health care, your greater risks were small numbers of patients and the more patients you have disseminate the risk out among the larger population. So if there is a car wreck with six people in it and you have a hundred and eighty-seven, it's different than if such a tragic event would occur in a patient enrollment with ten thousand. So, *we were at risk. The program had not grown as projected, capitation was less, and our consultant's recommendation was that we stay at that point in time with Health Care Plus.*

(Tran. 26, pp. 4195-97; emphasis added.)

44. The Wichita Clinic advised HMOK of its decision to terminate its HMOK primary care physician contracts by letter dated July 19, 1984. (Def.'s Ex. 456.) The letter stated the "decision was made solely on the basis of our best business judgment that a discontinuance of these primary care contracts would be in the best interests of all concerned." (*Id.*) The July 19 letter further advised that the Wichita Clinic's decision was not intended to affect Referral Physician Agreements signed by certain referral specialists at the clinic, indicating the clinic's desire that those agreements continue in effect. (*Id.*)

45. When the Wichita Clinic terminated its contract with HMOK, the only HMO with whom the clinic was then under contract was HCP. By letter dated August 16, 1984, Ben Boldt (Wichita Clinic's business manager) indicated the clinic's interest in pursuing a possible exclusive contractual relationship with HCP. (Def.'s Ex. 392.) However, no such contract was ever prepared or signed (Tran. 17, pp. 2958-59; Tran. 26, p. 4201), and the clinic has never been party to an exclusive contract with HCP. (Tran. 26, p. 4156.) The Wichita Clinic has maintained an "exclusive" relationship with HCP since 1984 solely by virtue of not having entered into any contracts with other HMOs. (Tran. 26, p. 4201.) But this relationship can be terminated by the clinic at any time in the clinic's sole discretion, and there is no limitation whatsoever on the clinic's ability to contract with another HMO or other prepaid plans.

(*Id.*)

46. Dr. Hummer explained this variety of "exclusivity" from the Wichita Clinic's perspective as follows:

> It was never and still is not the intent of the Wichita Clinic to commit themselves exclusively to any particular product at any one point in time. We may choose to participate with one or more of similar plans, depending upon the business sense of that decision. If it makes business sense at one point in time to remain with one plan for a period of time, then that's the decision that's made based on the numbers and the business judgment at the time. That could be changed at any time should it be Advantageous for the group to change.
>
> Q. (By Mr. Shulman) You understand an exclusive arrangement between a provider and an HMO to be an arrangement where the provider does business only with that HMO and not with other HMOs?
>
> A. As long as it's to the Wichita Clinic's advantage from a business sense to do that, yes, but not on a long term commitment.
>
> Q. An exclusive arrangement or agreement is an arrangement or agreement where a provider does business only with one HMO and not with others.
>
> A. It's a conscious choice of the provider to do business with any of a number of

competing plans according to what is best for them at the time.

(Tran. 26, pp. 4165-66.)

47. HCP representatives had the same understanding of the "exclusive" arrangement between the Wichita Clinic and HCP, namely, that it was an "exclusive" arrangement only in the sense that, as a matter of fact, the Wichita Clinic had decided to contract only with HCP, an arrangement which could be terminated at any time if the clinic decided to do so. (Tran. 17, p. 2958; Tran. 25, pp. 3981-82, 4021-23.)

48. The parties' understanding of the nature of their arrangement has been borne out in practice, since the Wichita Clinic has continued to negotiate with HMOK on various proposals since the summer of 1984, including a February, 1985 HMOK proposal regarding the formation of a group model HMO in Wichita. (Tran. 7, pp. 1142-48; Tran. 8, p. 1372; Tran. 25, p. 4056; Tran. 26, p. 4204; Def.'s Ex. 461; Pltfs.' Ex. 490.) Similarly, the Wichita Clinic subsequently signed with the St. Francis Regional Medical Center's PPO (Tran. 26, pp. 4152, 4193), the Sedgwick County Medical Society PPO and the Aetna PPO. (Dkt. 119, Hummer Depo., pp. 76-77.) Throughout this period, physicians at the Wichita Clinic have also continued as contracting providers under the BCBSK CAP program, defendant's basic indemnity insurance program. (*Id.*)

49. Marlon Dauner, BCBSK's senior vice president for external affairs, testified at trial he is aware of no facts to suggest that the Wichita Clinic would not be receptive to a good business proposal from HMOK. (Tran. 8, p. 1392.) At the same time, however, he also observed that HMOK's capitation rates are still lower than those of HCP. (*Id.*, pp. 1390-91.)

-- Hillside Medical Office --

50. As discussed, Hillside Medical Office signed a contract with HMOK in the fall of 1983. The contract had an effective date of March, 1984. (Tran. 16, p. 2688.) Similar to the Wichita Clinic, Hillside Medical Office was under contract with HCP at the time it entered into its contract with HMOK. (Compare Tran. 16, p. 2688 with p. 2706.)

51. While it was under contract with HMOK, Hillside Medical Office cooperated fully with the BCBSK HMO. (Tran. 16, p. 2691.) At no time did anyone from HCP seek to discourage Hillside Medical Office from participating with HMOK. (*Id.*, p. 2706.)

52. In July of 1984, Hillside Medical Office decided to terminate its contract with HMOK. At that time, Hillside Medical Office had only 52 HMOK members among the five physicians in the office. (Pltfs.' Ex. 511.) During its six month participation with HMOK, Hillside's capitation payments from HMOK grew from $200 to just $550

per month, compared to a growth from $800 to $14,000 per month during its first six months with HCP. (Tran. 16, p. 2695.)

53. The extremely low level of capitation payments received from HMOK was insufficient to cover even a significant number of routine office visits per month, much less a catastrophic illness. (Tran. 16, pp. 2691-95; Tran. 27, pp. 4379-81; Pltfs.' Ex. 511.) Nor did there seem to be any prospect of improvement in HMOK's performance, particularly since HMOK had assigned only two marketing representatives to the Wichita area, and its media advertising was virtually nonexistent. (Tran. 16, pp. 2696-97; Tran. 27, p. 4401; Pltfs.' Ex. 511.)

54. Hillside Medical Office therefore concluded the financial risk associated with HMOK was too great to justify continued participation. (Tran. 16, p. 2697.) By letter dated July 11, 1984, Hillside advised HMOK as follows:

> This letter is to inform you that the physicians of Hillside Medical Office want to terminate their agreement with HMO Kansas according to Article V of the Agreement. It is our understanding that this termination will be effective 30 days from the date of this letter.
>
> There are several reasons for requesting termination, and we would briefly cite a couple. The rate of growth for HMO Kansas is very slow in Wichita, and it is our feeling that HMO

> Kansas is not actively pursuing a marketing program to help accelerate or stimulate the growth. It is our understanding that only two marketing people serve this area containing the greatest concentration of people in the state. Fifty-two members in 3-1/2 months for an office of five physicians is not sufficient to establish a workable base for this type program. As you know, numbers are vital.
>
> The low capitation rate under the Basic Plan and the 25% withholding for the referral fund does not leave an adequate compensation for the primary provider to cover the most meager in-house fee for services charged on the HMO Kansas patient. On the other hand, the larger capitation rate under the full risk plan is more realistic but is immediately offset by the cost of referrals, and certainly places the primary care physician in a precarious financial position with the low subscription level.
>
> Rather than continue for an additional time, and exposing ourselves to additional patient encounters and referrals, we believe and feel now is the time to terminate the agreement.

(Pltfs.' Ex. 511.)

55. The Hillside physicians' decision to terminate the HMOK contract was unanimous. (Tran. 16, p. 2711; Tran. 27, p. 4399.) Dr. Reazin

testified the above-quoted letter accurately sets forth Hillside Medical Office's reasons for terminating that contract. (Tran. 16, p. 2704; see also pp. 2691-95.) His testimony was corroborated by Dr. Conrad Osborne, another member of the Hillside group (Tran. 27, pp. 4379-81), and by Paul Pfortmiller, Hillside's business manager, who authored the July 11 letter. (*Id.*, pp. 4388, 4399-4402.)

56. After Hillside Medical Office terminated its contract with HMOK, it was an "exclusive" HCP provider only in the sense it was not being marketed by any other HMO. (Tran. 17, pp. 2961-62.) However, there is no limitation on Hillside Medical Office's ability to enter into arrangements with HMOK or any other prepaid health care financing plans. (Tran. 27, p. 4383.) All physicians at Hillside Medical Office are contracting providers under the BCBSK CAP program. (Tran. 16, pp. 2671-72, 2705.) Additionally, the Hillside group, in early 1985, submitted a bid to participate in Choice Care, BCBSK's PPO. (*Id.*, p. 2705; see also SMF ¶83, *infra*.)

-- Unilateral Decisions --

57. There is no evidence any medical group in Wichita agreed with any other group not to do business with HMOK, nor that any groups reached their respective decisions regarding HMOK in consultation with or even with information

concerning any other group. Dr. Hummer testified that when the Wichita Clinic made its decision to terminate its contract with HMOK, he was not aware that Hillside Medical Office was also discontinuing its contractual relationship with BCBSK's HMO. (Tran. 26, p. 4176.) He had never spoken to anyone at Hillside regarding their intentions with respect to HMOK, and he did not have any idea that Hillside Medical Office had any intention to terminate its contract with HMOK. (*Id.*, p. 4202.) He was not even aware that Hillside Medical Office had terminated its contract with HMOK until the time of his deposition in February, 1986. (*Id.*, p. 4176.)

58. Dr. Reazin of Hillside Medical Office testified he had no knowledge concerning the Wichita Clinic's intentions regarding HMOK when Hillside made its decision to terminate the HMOK contract. He further testified he did not have any information concerning what any other doctors in Wichita were doing with respect to HMOK. (Tran. 16, pp. 2704-05.) According to Dr. Reazin, the actions or intentions of other groups with respect to HMOK "wouldn't have changed my mind a bit because it wouldn't have changed my numbers here . . . We were looking at low enrollment and we made our decision based on that." (*Id.*) He further testified that if HMOK had been successful in attracting subscribers, "I'd still be with them today." (*Id.*, pp. 2696-97.)

59. Dr. Conrad Osborne, Dr. Reazin's partner at Hillside Medical Office, testified to the same effect, stating that when Hillside made its decision to terminate its HMOK contract in July, 1984, he had no knowledge what the Wichita Clinic was doing with respect to HMOK. (Tran. 27, pp. 4373-7382.) He did not learn that the Wichita Clinic had terminated its HMOK contract until long after the fact. (*Id.*, p. 4373.) Dr. Osborne further testified that Hillside Medical Office's decision was made independently, without any input from anyone else. (*Id.*, p. 4382.)

60. Dr. Donald Ray Cook, a family practice sole practitioner associated with Medical Arts Health Care Associates, P.A., testified that he reached his decision not to contract with HMOK without having any knowledge regarding whether other physicians were entering into contracts with the BCBSK HMO. (Tran. 29, pp. 4744-45.) He testified he would have considered signing with HMOK if it had been in his own financial interest to do so. (*Id.*, p. 4767.)

61. Dr. Stanley Mosier of Family Physicians, P.A., a family practice group which decided against participating with HMOK in the summer of 1983 (See SMF ¶27, *supra*), similarly testified that he did not discuss HMOK with other medical groups in Wichita (*Id.*, pp. 4271, 4275), nor did he have any knowledge as to the status or intentions of any other group when Family Physicians, P.A. made its decision. (Dkt. 118, Mosier Depo., pp. 28-29, 32,

60-65.)

-- HCP Stock --

62. As discussed, HCP offered stock to various investors, including certain physicians, in March of 1984. This stock was actually issued to subscribing investors in August of 1984. (See SMF ¶10, *supra*.) Certain primary care physicians, including the Wichita Clinic, Dr. Reazin, Dr. Osborne, Dr. Mosier, and Dr. Cook, purchased HCP stock in connection with this offering. (Tran. 17, p. 2940; Tran. 16, p. 2707; Tran. 27, p. 4372; Tran. 26, p. 4262; Tran. 29, p. 4744.) Although these physicians hoped HCP stock would be a good investment, it was generally perceived as a risky investment. (Tran. 16, p. 2710; Tran. 26, pp. 4150, 4233; Tran. 29, p. 4763.)

63. It was not required that physicians do business with HCP, "exclusively" or otherwise, as a condition to being allowed to purchase HCP stock. (Tran. 17, p. 2938; Tran. 25, pp. 3977- 80; Tran. 26, p. 4268; Tran. 29, p. 4763.) Those physicians and groups who declined to participate with HMOK and/or who discontinued such participation have articulated independent business reasons for their decisions, which were wholly unrelated to any investment in HCP. (See SMF ¶¶ 26-27, 43, 54-55, *supra*.) There is no evidence that any physician's investment in HCP influenced his decision regarding whether to participate with HMOK. In fact, the evidence of record conclusively establishes that HCP

stock holdings played no part in the respective decisions of any groups at issue in this litigation.

64. For example, Family Physicians, P.A. decided not to contract with HMOK in the summer of 1983. (SMF ¶27, *supra*.) HCP stock was not even being offered at that time. (SMF ¶10, *supra*.)

65. Dr. Reazin testified his investment in HCP had no effect on his decision to discontinue his affiliation with HMOK. (Tran. 16, p. 2710.) Dr. Osborne also testified Hillside Medical Office's decision regarding HMOK had nothing to do with his HCP investment. (Tran. 27, p. 4381.) According to Dr. Osborne, "those were totally independent decisions." (*Id.*)

66. This direct testimony is corroborated by the fact that as a group, Hillside Medical Office *declined* to purchase HCP stock. (Tran. 16, p. 2708.) Further, only Drs. Reazin and Osborne individually decided to acquire HCP stock while their three partners at Hillside declined to do so, yet the decision to terminate the HMOK contract was *unanimous*. (*Id.*, p. 2711.)

67. Similarly, HCP's stock offering to the Wichita Clinic was unrelated to any notion of exclusivity. (Tran. 25, pp. 3977-80.) Nor was the Wichita Clinic's purchase of HCP stock connected in any fashion to the clinic's consideration of possible participation in other prepaid plans. (Tran. 26, p. 4152.) Rather, the HCP stock purchase was merely viewed as an investment opportunity, the desirability

of which was decided by a 4 to 3 vote by the clinic's executive committee. (Tran. 26, pp. 4148, 4151; Def.'s Ex. 452.)

68. Dr. Donald Ray Cook was one of six physicians associated with Medical Arts Health Care Associates, P.A. (SMF ¶60, *supra*.) Within that group, Dr. Cook alone purchased HCP stock. (Tran. 29, p. 4762.) Dr. Cook individually decided not to contract with HMOK, and he did not know whether any of the other physicians associated with his group contracted with HMOK. (*Id*., p. 4744-45.) Dr. Cook's individual reasons for deciding not to contract with HMOK had nothing to do with his investment in HCP. (*Id*., pp. 4762-63.)

-- Hospital Corporation of America --

69. On April 25, 1985, HCA acquired New Century from E. F. Hutton. (Stip. u.; Tran. 19, p. 3182.) Although New Century was licensed to do business in over 30 states, including Kansas, it was basically a "shell" corporation without any active operations. (Stip. f.; Tran. 19, p. 3182.) New Century is not yet actively engaged in health care financing in Kansas. (Stip. f.)

70. In October of 1984, representatives from Wesley contacted HCA and indicated Wesley's potential interest in being acquired by HCA. (A. B. Davis Depo., pp. 69-75.) Negotiations ensued, and the sale was publicly announced in November of

1984. (Tran. 1, p. 36.) HCA acquired Wesley on July 11, 1985. The acquisition was effected to HCA Health Services of Kansas, Inc., a wholly-owned subsidiary of HCA. (Stip. v.)

71. In late 1984, HCP began planning toward national expansion of its HMO operations. Recognizing that additional capital would be needed to finance that expansion, HCP began talking to investment bankers, venture capitalists, and other institutional investors. (Tran. 17, pp. 2963-64.) In the spring of 1985, HCP began discussing its plans with HCA. (*Id.*, pp. 2965-66.) Initial discussions focused on the possibility of HCA making an investment in HCP as opposed to purchasing the company. (*Id.*, pp. 2966-67.) Ultimately, it was decided to sell HCP to HCA. (*Id.*, p. 2967.) The proposed transaction was publicly announced on May 30, 1985. (Def.'s Ex. 239.)

72. When HCA decided to acquire Wesley in late 1984, HCA was not contemplating the possible purchase of an HMO in Wichita. (Tran. 19, p. 3181.) HCA was interested in acquiring HCP because its management expertise and management systems offered the potential for national expansion. (Tran. 19, p. 3181; Tran. 20, pp. 3263-64; Tran. 21, p. 3330; Tran. 25, pp. 4084-85.) Neither HCP's presence in Wichita nor HCA's pending acquisition of Wesley were relevant to HCA's decision to acquire HCP. (Tran. 19, p. 3181.)

73. HCA did not examine HCP's presence in Wichita in any great detail, because HCA's interest in HCP was not focused on local considerations. (Tran. 20, pp. 3263-64.) HCP's local physician list was discussed only in a limited fashion, and the existence of "exclusive" arrangements with physicians (or the lack thereof) played no role in the negotiations between HCA and HCP. (Bugg Depo., pp. 116-18; Kardatzke Depo., p. 58.) Indeed, this subject was not even discussed in connection with the transaction. (Tran. 17, pp. 2967-68.) As a result, none of the HCA representatives involved in the negotiations had any knowledge concerning any putative "exclusive" arrangements between HCP and physicians' groups. (Dkt. 118, Reeves Depo., pp. 30-31.)

74. On August 14, 1985, HCA consummated its acquisition of HCP. HCA acquired the stock of HCP through a merger of HCA Acquisition Corp. of Kansas, Inc. into HCP. (Dkt. 161, Memo. in Support of Ctrclm. Defs.' Motion for Summ. Judg. on Ctrclm., Att'd Aff. of Charles L. Kown and Att'd Ex., "Agreement of Merger".)

Paragraph 1 of the Agreement of Merger provided that HCP was the Surviving Corporation and that:

> [t]he Surviving Corporation shall thereupon and thereafter without other transfer succeed to all the rights and property, subject to all debts and liabilities, of Health [Care] Plus and [HCA Acquisitions Corp. of Kansas, Inc.] in the same

> manner as if the Surviving Corporation itself had incurred them . . . .

(*Id.*)

75. Wesley has been under contract with HCP since 1981. (Tran. 22, p. 3687.) In the fall of 1984, prior to any contact between HCA and HCP regarding a possible acquisition, HCP and Wesley successfully negotiated a capitation contract with an effective date of January 1, 1985. (Tran. 17, pp. 2976-78; Tran. 22, pp. 3687-88.) Although Wesley was the first hospital in Wichita to enter into a capitation contract with HCP, HCP also had fee-for-service contracts with the other hospitals in Wichita at that time. (Tran. 17, pp. 2968-70.)

76. HCP's existing relationship with Wesley had no bearing on HCA's decision to acquire HCP. (Tran. 19, p. 3181.) In fact, HCP made it clear from the outset that its existing model involved dealing with all hospitals, and that HCP would not be interested in pursuing discussions with HCA if HCA might require HCP to deal exclusively with HCA hospitals. (Tran. 17, pp. 2968-69.) HCA agreed that HCP could continue to deal with any and all hospitals in Wichita and elsewhere. (*Id.*, p. 2969.)

77. From the time of its acquisition of HCP, HCA has made no effort to require HCP to do business only with Wesley, and HCP has continued to do business with the other hospitals in Wichita. (Tran. 17, pp. 2969-70.) HCP entered into capitation contracts with St. Francis Regional Medical Center,

in Wichita, in July of 1985 (after the HCA letter of intent had been executed), and with St. Joseph Medical Center, in Wichita, in April of 1986 (after HCP had been acquired by HCA). (Tran. 17, p. 2970.) Under these contracts, it may be more advantageous for HCP to send members to St. Francis or St. Joseph, rather than Wesley, under certain circumstances, and HCP continues to desire to have its members utilize all three hospitals. (*Id.*, p. 2984.)

78. HCA adheres to a policy of decentralized management with respect to its subsidiaries' operations. (Tran. 19, pp. 3144-45.) Both HCP and Wesley have continued to operate under the direction of their local, preacquisition management personnel, who operate autonomously in conducting the day-to-day operations of their respective organizations. (Tran. 1, p. 38; Tran. 17, p. 2971; Tran. 19, p. 3175; Tran. 22, p. 3683.) Dealings with HCA are limited mainly to budgetary approval. (Tran. 17, p. 2971; Tran. 22, p.3684.)

79. HCA does not have any practice or policy involving special arrangements between its subsidiary hospitals and HMOs, leaving such matters to the discretion of local management of the institutions involved. (Tran. 19, pp. 3147-48.) This general policy has been observed with respect to dealings between HCP and Wesley. (*Id.*, pp. 3146-47.) HCA has not involved itself in dealings between HCP and Wesley, requiring both firms to negotiate

arrangements satisfactory to each. (*Id.*)

80. There have been no changes in HCP's relationship with Wesley since the HCA acquisitions -- a relationship which continues to be characterized by arms-length negotiations. (Tran. 17, p. 2974; Tran. 22, p. 3690.) There has been no discussion of any type of "exclusive" arrangement between HCP and Wesley, either before or after HCP's acquisition by HCA. (Tran. 22, pp. 3688-3692.)

81. Wesley has participated with BCBSK as a contracting provider under its indemnity insurance program since BCBSK's inception. (Stip. q.; Tran. 4, p. 630.) Wesley has always cooperated fully with BCBSK, and Wesley has continued to do so after being acquired by HCA. (Tran. 4, pp. 630, 640.)

82. Wesley entered into a provider contract with HMOK in November, 1983. Wesley was already under contract with HCP at that time. (Tran. 22, pp. 3688-89.) Wesley's contract with HMOK is still in effect (*Id.*), and HCP has never attempted to interfere with Wesley's contractual arrangement with HMOK. (*Id.*, pp. 3689-90.)

-- Post-Acquisition Developments --

83. In the spring of 1985, BCBSK began efforts to establish a PPO in Wichita. This PPO was known as "Choice Care". (Tran. 4, p. 631.) BCBSK solicited bids from all four Wichita hospitals to participate as preferred providers in the Choice Care

program, and in the summer of 1985 BCBSK selected Wesley and St. Francis as Choice Care hospitals based on this competitive bidding process. (*Id.*) During this same period, BCBSK was successful in securing contracts with Wichita area physicians to participate in its new PPO. (Tran. 12, pp. 2056-58; Pltfs.' Ex. 358.)

84. BCBSK decided to discontinue development of Choice Care in Wichita in August, 1985. This decision was prompted by BCBSK's determination it would seek to terminate Wesley's contracting provider agreement under the CAP program. (Tran. 4, pp. 646-48; Pltfs.' Ex. 168.)

85. In the summer and fall of 1985, BCBSK developed an arrangement with Kansas Health Plan, a newly formed joint venture between St., Joseph Medical Center and St. Francis Regional Medical Center. Pursuant to this arrangement, BCBSK has reintroduced HMO Kansas into Wichita, offering a new HMO product in competition with HCP. (Tran. 8, p. 1336; Tran. 11, pp. 1907-08; Tran. 14, pp. 2316-17.)

86. More recently, BCBSK has renewed development of its Choice Care PPO in Wichita. BCBSK anticipates that Choice Care will offer lower premiums to its subscribers. (Tran. 8, p. 1338.)

87. BCBSK continues to be the largest provider of private health care financing in the State of Kansas and in Sedgwick County. (Stip. j.) Between 1983 and 1984, BCBSK experienced a net gain of 10,000 insurance contracts. (Tran. 21, pp. 3378-80;

Def.'s Ex. 663.) Using a conservative estimate of BCBSK's market share of the insurable population in Kansas, BCBSK's market share increased from 43% to 47% during the period 1983 to 1985. (Tran. 21, pp. 3393-94.)

88. In 1986 HCA decided to withdraw from the health care financing business. This withdrawal will be effected through a joint venture with the Equitable Insurance Company. HCA will contribute all of its health care financing business, including HCP, to the joint venture in return for an initial 50% stock interest in the newly formed company. The joint venture corporation will have a separate board of directors and separate management. The corporation ultimately will be a publicly held company, and HCA therefore anticipates that its 50% interest will be diluted rapidly. (Tran. 20, pp. 3203-04.)

Conclusions of Law.

-- §1 Claims --

The counterclaim plaintiffs (hereinafter "BCBSK") advance two principal claims under §1 of the Sherman Act. First, BCBSK alleges a per se violation of §1 stemming from an alleged conspiracy with providers in 1984 to terminate contracts and refuse to deal with HMO Kansas. Alternatively, BCBSK alleges HCP entered into "exclusive dealing arrangements" with various physician groups pursuant

to which those groups agreed not to do business with HMOK.

These claims provide no basis for relief against counterclaim defendants Wesley Medical Center or New Century. There is no evidence that Wesley was a participant in any such conspiracy or that it was a party to any allegedly unlawful contract. Nor is there any evidence linking New Century, which has not yet even begun doing business in Kansas, to any allegedly unlawful acts.

Nor do these allegations state any claim for relief against HCA. HCA did not begin discussions with HCP until the spring of 1985, long after the activities alleged in the counterclaim had taken place. The evidence further shows that HCA had no knowledge of any purported conspiracy or "exclusive dealing arrangements" between HCP and providers in Wichita. The mere fact HCA subsequently acquired HCP's stock is not sufficient to render HCA liable for the allegedly unlawful acts of its subsidiary. *Quarles v. Fuqua Industries*, 504 F.2d 1358, 1362 (10th cir. 1974); *Murphy Tugboat Co. v. Ship Owners & Merchants Towboat Co., Ltd.*, 467 F.Supp. 841, 854 (N.D. Cal. 1979), *aff'd* 658 F.2d 1256 (1981), *cert. denied* 455 U.S. 1018 (1982); *First Stop Book Shop, Inc. v. Matthews Book Co.*, 476 F.Supp. 1054, 1056 (E.D. Mo. 1979), *rev'd on other grounds* 634 F.2d 396 (8th Cir. 1981).

Counterclaim defendants HCP and Dr. Reazin have denied BCBSK's §1 claims and have offered

substantial evidence corroborating those denials. To survive summary judgment, BCBSK must therefore establish there is a genuine issue of material fact as to whether HCP and/or Dr. Reazin entered into an illegal conspiracy or agreement. If the record taken as a whole could not lead a rational trier of fact to find for BCBSK on this issue, HCP and Dr. Reazin are entitled to summary judgment on the §1 claims. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. , 89 L.Ed.2d 538, 106 S.Ct. 1348, 1355-56 (1986).

No direct evidence implicates anyone in a conspiracy to "boycott" HMOK, and BCBSK therefore must rely on inferences from the evidence to establish the existence of the alleged conspiracy. In this case, Dr. Reazin and the other physicians who allegedly participated in the conspiracy to boycott HMOK have articulated independent business justifications for their respective decisions regarding dealings with HMOK. The reasons advanced by these providers were uniformly corroborated by contemporaneous documents, including HMOK's own internal memoranda and minutes.

While true, on summary judgment the inferences to be drawn from the underlying facts must be viewed in the light most favorable to the party opposing the motion, it is also true that antitrust law limits the range of permissible inferences from ambiguous evidence in a §1 case. *Matsushita*, 89 L.Ed.2d at 553, 106 S.Ct. at 1356.

> [C]onduct as consistent with permissible competition as with illegal conspiracy does not, standing alone, support an inference of antitrust conspiracy. . . . To survive a motion for summary judgment or for a directed verdict, a plaintiff seeking damages for violation of §1 must present evidence "that tends to exclude the possibility" that the alleged conspirators acted independently. . . . [Plaintiffs], in other words, must show that the inference of conspiracy is reasonable in light of the competing inferences of independent action or collusive action that could not have harmed [them].

89 L.Ed.2d at 553, 106 S.Ct. at 1357 (citations omitted; quoting *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752, 764 (1984)). *Matsushita* establishes a two-part inquiry for evaluating the propriety of summary judgment in an antitrust conspiracy case: (1) whether a plaintiff's evidence of conspiracy is ambiguous, i.e., whether it is as consistent with the defendants' permissible independent interests as with an illegal conspiracy; and, if so, (2) whether there is any evidence tending to exclude the possibility that the defendants were pursuing these independent interests. *Gibson v. Greater Park City Co.*, Nos. 84-1829, 84-2209, slip op. at 3 (10th Cir. May 7, 1987).

BCBSK's attempt to infer a conspiracy from the terminations of HMOK's contracts with Hillside and Wichita Clinic does not survive the *Matsushita/Greater Park City Co.* standards. Resolving all permissible inferences in favor of BCBSK, the evidence is *at best* ambiguous because those contract terminations are as consistent with counterclaim defendants' and the physicians' permissible independent interests as with an illegal conspiracy. But that ambiguity fails to create any genuine issue of material fact because BCBSK provides *no* evidence tending to exclude the possibility counterclaim defendants and the physicians were pursuing these independent interests. First, the undisputed facts demonstrate both of these physician groups made independent unilateral decisions to terminate their respective relationships with HMOK. Neither group was aware of the other's decision to terminate until after the fact. (SMF ¶¶ 57-59.) Second, the evidence establishes the decision of each group was in its individual financial interest because HMOK's small subscriber base subjected those groups to unacceptable financial risks, particularly in light of HMOK's unattractive reimbursement provisions. (SMF ¶¶ 43, 52-55.) The foregoing facts are also true as to those groups which declined to contract with HMOK from the outset. (SMF ¶¶ 26-28.) Indeed, BCBSK's own contemporaneous internal documents demonstrate

that HMOK's difficulties in recruiting and retaining physicians were due to the limitations in its own program and the superiority of HCP's program. (SMF ¶¶ 30-33.)

The fact HCP sought to convince physicians that it was in their best interests to continue to deal with HCP does not support any inference of conspiracy. An HMO's provider list is an integral part of the HMO itself, and efforts to develop and maintain that list are part and parcel of the normal competitive process. (SMF ¶¶ 5, 31-33, 37, 40.) There is absolutely no evidence any physician group made its decision to deal with HCP, as opposed to HMOK, on any basis other than the relative competitive merits of the two programs. (SMF ¶¶ 26-27, 43-44, 52-55.)

Nor can a conspiracy be inferred from the fact certain HCP providers were also shareholders of HCP. It is not contradicted HCP offered stock to contracting physicians, *noncontracting* physicians and even *nonphysicians*. (SMF ¶10.) As to contracting physicians, HCP placed no conditions on the availability of its stock that the physician must do business "exclusively" with HCP or refrain from doing business with other HMOs. (SMF ¶¶ 11, 14, 62-68.) That a provider's financial interest in HCP might have created an additional incentive to deal with HCP -- or, conversely, *not* to deal with a competitor of HCP -- is not sufficient to infer a conspiracy. This is especially true here, since the unrebutted

testimony elicited at trial demonstrates HCP stock played no part whatsoever in the decision of any provider regarding HMOK. (SMF ¶¶ 62-68.)

Nor is there any genuine issue of material fact regarding BCBSK's "exclusive dealing" claim. First, it is undisputed HCP did not impose any contractual limitations upon any group's ability to contract with HMOK. Groups under contract with HCP, which declined to contract with HMOK, were offered "exclusively" by HCP only in the sense they had independently decided not to be marketed by any other HMO. Such arrangements were thus "exclusive" only in the descriptive sense, not as "exclusive dealing arrangements" designed, intended and implemented as those for which the antitrust laws provide relief. That the independent economic self-interest of various medical groups dictated participation with HMOK was *not* desirable does not raise any inference of conspiracy or "exclusive dealing" cognizable under the antitrust laws.

Thus, the evidence of record, viewed most favorably to BCBSK, shows only that certain physician groups in Wichita independently decided not to do business with HMOK based on an assessment of the acknowledged deficiencies of the HMOK program. That those groups were therefore dealing "exclusively" with HCP merely describes the status quo: having decided not to contract with HMOK, those groups' HMO involvement was *de facto* limited to their relationship with HCP. An

arrangement which is "exclusive" in the descriptive sense, in that a company is only dealing with a single firm, but is not restrictive in any way of the rights of other buyers or sellers, is simply not an "exclusive dealing arrangement" cognizable under the antitrust laws.

Further, even if HCP's relationships with certain Wichita physician groups could be characterized as "exclusive dealing arrangements", HCP would still be entitled to summary judgment because the existence of such arrangements does not raise a triable issue under §1. The mere existence of an exclusive dealing clause does not violate the antitrust laws. *See Bob Maxfield, Inc. v. American Motors Corp.*, 637 F.2d 1033, 1036 (5th Cir.), *cert. denied* 454 U.S. 860 (1981). An exclusive dealing claim does not present a per se violation of §1. *Instructional Sys. Dev. Corp. v. Aetna Cas. and Surety Co.*, No. 82-2105, slip op. at 7-8, 11 (10th Cir. Apr. 22, 1987). Rather, "exclusive dealing arrangements" are analyzed under the rule of reason, and thus condemned only upon an affirmative showing that they restrain trade unreasonably. *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 45 (1984) (O'Connor, J., concurring); *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320, 329, 334 (1961); *Roland Machinery Co. v. Dresser Industries*, 749 F.2d 380, 393 (7th Cir. 1984).

Among other things, this means a plaintiff seeking to challenge an "exclusive dealing

arrangement" must demonstrate the defendant possesses market power, as this is a prerequisite to being able to restrain trade unreasonably. *Westman Com'n Co. v. Hobart Intern., Inc.*, 796 F.2d 1216, 1225 (10th Cir. 1986); *Jack Walters & Sons Corp. v. Morton Building, Inc.*, 737 F.2d 698, 702 (7th Cir.), *cert. denied* 105 S.Ct. 432 (1984); *Valley Liquors, Inc. v. Renfield Importers, Ltd.*, 678 F.2d 742, 745 (7th Cir. 1982). Thus, to establish the existence of a genuine issue of material fact as to its "exclusive dealing" claim, BCBSK must produce evidence tending to show HCP possesses "market power", which the Tenth Circuit has defined as "the power to control prices" or "the power to exclude competition." *Hobart*, 796 F.2d at 1225 n. 3; *see also Board of Regents of Univ. of Oklahoma v. NCAA*, 707 F.2d 1147, 1158 (10th Cir. 1983), *aff'd* 468 U.S. 85 (1984).

The facts of record establish HCP lacks market power, and HCP is therefore entitled to summary judgment on BCBSK's "exclusive dealing" claim even if such arrangements, in the antitrust sense, could be shown to exist. The evidence shows HCP competes with well over 200 firms in this market. (SMF ¶¶ 15, 19, 20.) HCP is a relatively minor player in the private health care financing market in Kansas, with a market share of less than 3% based on premium dollars. (SMF ¶16.) Indeed, even within greater Sedgwick County, its 1985 market share was only between 8% and 12%. (SMF ¶21.)

In an effort to avoid summary judgment on this

ground, BCBSK seeks to posit a separate "submarket" consisting exclusively of HMOs wherein HCP might be said to possess market power. In support of the alleged existence of this "submarket", BCBSK relies exclusively on the affidavit of its expert, Peter R. Hamilton. (Dkt. 266, Memo. in Opp. to Motion for Summ. Judg. on the Ctrclm., Att'd Aff. of Peter R. Hamilton.) Dr. Hamilton's affidavit, however, is wholly inadequate to raise a genuine issue of fact as to the existence of the insupportable and unduly restrictive "submarket" alleged by BCBSK.

Indeed, the affidavit does not even rise to the level of admissible evidence as required by Fed.R.Civ.P. 56. An expert's affidavit submitted in opposition to a motion for summary judgment must set forth specific facts from the record to support its conclusions. *Evers v. General Motors Corp.*, 3 Fed.R.Serv. 3d 9-59, 962 (11th Cir. 1985); *United States v. Various Slot Machines*, 658 F.2d 697, 700-01 (9th Cir. 1981); *Merit Motors, Inc. v. Chrysler Corp.*, 569 F.2d 666, 672-73 (D.C. Cir. 1977). Theoretical speculation, unsupported assumptions and conclusory allegations advanced by an expert are neither admissible at trial, *see, e.g., American Bearing Co. v. Litton Industries, Inc.*, 540 F.Supp. 1163, 1171-75 (E.D. Pa. 1982), *cert. denied* 469 U.S. 854 (1984), nor are they entitled to any weight when raised in opposition to a motion for summary judgment. *See Evers, supra*; *Various Slot Machines*,

supra; and *Merit Motors*, *supra*. As applied to Dr. Hamilton's affidavit, these principles demonstrate his conclusory assertions respecting the alleged existence of an "HMO submarket" are entitled to no weight.

It is undisputed HMOs compete with traditional indemnity insurance products, PPOs and self-insured programs. (SMF ¶21.) Nor is it disputed all of these health care financing mechanisms are included within the "private health care financing market" (*Id.*), which BCBSK stipulated is the relevant market in this case. Indeed, Dr. Hamilton himself testified in deposition that "at the least," indemnity insurers, PPOs, HMOs, other prepaid health plans and self-insurance would be included in the relevant market in this case. (Hamilton Depo., p. 84.) Moreover, Dr. Hamilton's deposition testimony flatly contradicts the theory he now postulates in his affidavit:

> Q. [By Mr. Rawson] [W]hat is your, as an economist, definition of a sub-market?
>
> Q. *Sub-market to me is some definition of market which does not -- that if one firm owned all of the products in that particular market they still would not have the power to raise prices over a competitive price.* However, I believe by [*Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962)] [the] definition of a sub-market is that it is some definition of

market more constrained than what economists would call it but still has legal significance. *So to me a sub-market has no significance . . . .*

Q. All right. Let me ask the question this way. To you as an economist, are there any significant sub-markets geographically for health care financing in Kansas?

A. *I believe we've got the same objection. Sub-market can be anything we want to define it, as that has no significance . . . .*

. . . .

Q. *In your opinion is Wichita a geographic sub-market in health care financing?*

A. *No*, and I once again point out you have used the term that at least economically speaking is not well-defined, so my answer's always contingent on that. You have been insisting on using the term sub-market even though I haven't really defined it as anything you want to define it as other than a definition of market.

Q. Let me ask it this way: *Is Wichita a market for health care financing?*

A. *No.*

Q. Are there any ambiguities in that question as far as you're concerned as an economist?

A. No.

(Hamilton Depo., pp. 80-82; emphasis added.)

These undisputed facts are sufficient to dispose of Dr. Hamilton's conclusory affidavit and, correspondingly, of BCBSK's "HMO submarket" argument. The evidence of record conclusively establishes that HMOs are in direct competition with other methods of private health care financing, and that these alternative health care financing mechanisms are reasonably interchangeable. Viewed in light of the undisputed evidence of record, the unrealistically narrow "submarket" posited by BCBSK does not withstand scrutiny. *See United States v. E. I. du Pont de Nemours & Co.*, 351 U.S. 377, 395 (1956); *Telex Corp. v. Internat'l Business Machines Corp.*, 510 F.2d 894, 919 (10th Cir.), *cert. dism'd* 423 U.S. 802 (1975). *See also* BCBSK Preliminary Trial Brief dated Feb. 28, 1986, at pp. 76-77 ("The relevant market . . . is comprised of all third-party financers of health care . . . indemnity-type insurance, prepaid HMO plans, etc. are reasonably interchangeable health care products.") (citing *du Pont*, *supra*, and *Telex*, *supra*).

Dr. Hamilton's affidavit neglects the facts of record in favor of theory, and nothing contained therein raises any genuine issue as to the alleged existence of a separate HMO "submarket". His "economic analysis" (Aff., ¶¶ 7-13) is a hypothetical and circular exercise in which he attempts to bootstrap HMOK's lack of success in Wichita to the conclusion there is an HMO sub-market, the existence of which he "assumed" from the outset. (Aff., ¶7.) His "legal analysis" (¶¶14-18), for which he is not qualified, is equally defective. In an effort to make *Brown Shoe Co. v. United States*, 370 U.S. 294 (1962), fit this case, he argues HMOs are "a separate economic entity," because *inter alia* they are called "HMOs" (presumably calling for the same conclusion as to "Fords"), and because BCBSK "found it necessary" to separately incorporate HMOK (overlooking the fact this was required due to BCBSK' special enabling legislation). (¶15.) He argues the HMO "submarket" is served by "specialized vendors" (¶16), ignoring the fact both BCBSK and HCA are fully integrated providers of health care financing services, i.e., indemnity programs, HMOs, PPOs, and ASO services. Similarly, he disregards Aetna's presence in Wichita through indemnity insurance and a PPO product. Indeed, Dr. Hamilton excludes PPOs altogether, despite the facts they have many characteristics in common with HMOs and that they are in direct competition with HMOs and traditional indemnity insurance.

He goes on to assert that "*[s]ome* HMO's have 'distinct customers' that prefer the HMO method of delivery . . ." (¶17, emphasis added), ignoring the fact the actual "customers" consist primarily of employers who offer their employees both HMO and traditional indemnity programs, and who also have the option of establishing their own self-insured programs. Thus, Dr. Hamilton's argument is oblivious to the record as a whole, and additionally, by his own admission in deposition, amounts to poor economics. His affidavit is a classic example of why Fed.R.Civ.P. 56, as interpreted by the courts, requires an expert's opinions to be rooted *in fact* before they will be considered in opposition to a motion for summary judgment. *See Merit Motors*, 569 F.2d at 673 ("To hold that Rule 703 [regarding admissibility of expert testimony] prevents a court from granting summary judgment against a party who relies solely on an expert's opinion that has no basis in or out of the record than [the expert's] theoretical speculations would seriously undermine the policies of Rule 56.").

Under these circumstances, BCBSK cannot be heard to argue HCP possesses market power in the private health care financing market. BCBSK successfully recruited physicians in Wichita to participate in its Choice Care PPO during the period the alleged "exclusive arrangements" were in effect, and it has subsequently reintroduced HMOK in the Wichita area. (SMF ¶¶ 83, 85.) BCBSK anticipates

these competitive product offerings will reduce premiums to Wichita area subscribers. (SMF ¶¶ 85-86.) HCP's lack of market power is further demonstrated by the fact Wichita is also characterized by a large degree of competition in the form of self-insured programs. (SMF ¶20.)

The evidence conclusively establishes HCP lacks market power in the private health care financing market. HCP is therefore entitled to summary judgment on BCBSK's "exclusive dealing" claim. *See Hobart, supra*; *Assam Drug Co. v. Miller Brewing Co., Inc.*, 798 F.2d 311 (8th Cir. 1986) (applying federal precedent to exclusive territorial assignments challenged under South Dakota antitrust laws, summary judgment granted because defendant lacked market power); *Barnosky Oils, Inc. v. Union Oil Co. of Calif.*, 582 F.Supp. 1332 (E.D. Mich. 1984) (summary judgment granted in exclusive dealing case where defendant lacked substantial market share and competition was vigorous).

BCBSK's inability to establish HCP possesses market power, in itself, entitles HCP to summary judgment, *see Celotex Corp. v. Catrett*, *supra*, but BCBSK's "exclusive dealing" claim is deficient in other respects as well. None of the factors which courts have relied upon to invalidate exclusive dealing arrangements -- such as unreasonable duration, lack of business justification, or the risk that entry will be deterred -- are present here. *See In re Beltone Electronics Corp.*, 100 FTC 68, 204

and n. 39 (1982). Even crediting Dr. Hamilton's "HMO sub-market" hypothesis, BCBSK cannot avoid summary judgment on its "exclusive dealing" claim. The "exclusive" arrangements at issue constitute at-will relationships which could be terminated at any time in the sole discretion of the medical groups. (SMF ¶¶ 36-38, 45-48, 56.) Thus, even assuming such arrangements constitute "exclusive dealing" agreements within the meaning of the antitrust laws, the at-will nature of the arrangements would preclude any finding of illegality as a matter of law, even assuming HCP possesses market power in the contrived submarket. *See American Passage Media Corp. v. Cass Communications*, 750 F.2d 1470, 1473 (9th Cir. 1985) (market power alone is insufficient to establish anticompetitive harm from exclusive dealing contracts where contracts are terminable at will); *Roland machinery Co. v. Dresser industries, Inc.*, 749 F.2d 380, 395 (7th Cir. 1984) (exclusive dealing contracts terminable in less than one year are presumptively lawful under Section 3 of the Clayton Act, 15 U.S.C. §14); *see also Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320, 335 (1961) (arrangements which do not violate the broader proscription of Clayton Act §3 do not violate §1 of the Sherman Act).

In support of its §1 claims, BCBSK contends there is both "direct and circumstantial evidence of conspiracy." Its "direct evidence" consists of the deposition testimony of James Denman, the

deposition and trial testimony of Dr. Beth Alexander, and the minutes of the Wichita Clinic. Its "circumstantial evidence" includes "numerous meetings between Dr. Kardatzke and the Wichita physician groups, meetings of the Consortium, the timing of the Wichita [Clinic] and Hillside contract cancellations, the timing of the stock offers and issuance, and the inability of HMOK to contract with key physician groups in Wichita." The foregoing "evidence" is insufficient to avoid summary judgment on BCBSK's §1 claims.

BCBSK seeks to use Mr. Denman's testimony to support its contention HCP, through its stock offering and otherwise, elicited "exclusive dealing arrangements" from Wichita area physician groups. Mr. Denman's deposition testimony reveals, however, the proffered testimony is inadmissible because he is incompetent to testify as to HCP's dealing with Wichita area physicians. He testified, for example: "I did not work with the Wichita area physicians. I just heard of names and groups from time to time but was far too busy in other areas to work with physicians." (Denman Depo., p. 50.) He did not recall having any involvement whatsoever in recruiting physicians in Wichita. (*Id.*, p. 57.) Further, he testified he "was not at any time in the direct discussions with physicians leading to allocating or promising, committing blocks of Health Care Plus stock . . . ." (*Id.*, p. 48.) Indeed, he complained he was literally "locked out" of negotiations with doctors relating to the possible

purchase of HCP stock because he was not a member of HCP's upper management. (*Id.*, p. 19.) Lacking any foundation in his personal knowledge, Mr. Denman's testimony is barred by Fed.R.Evid. 602 ("A witness may not testify unless evidence is introduced sufficient to support a finding that he has personal knowledge of the matter.").

BCBSK next cites Dr. Alexander's testimony regarding, first, alleged statements made by members of Family Physicians, P.A., concerning contacts with other Wichita physician groups about doing business with HMOK. On this point, Dr. Alexander's testimony is inadmissible hearsay. Neither Family Physicians nor any individual members of that group are parties to this litigation. Dr. Alexander's testimony concerning alleged statements made by other members of Family Physicians is flatly prohibited by Fed.R.Evid. 802. BCBSK's attempted reliance on the "co-conspirator" proviso of Rule 801(d)(2)(E) is fruitless. "[A]cts and declarations of an alleged co-conspirator are admissible against another only if the *existence* of the conspiracy is in fact first established by independent evidence." *World of Sleep, Inc. v. La-Z-Boy Chair Co.*, 756 F.2d 1467, 1474 (10th Cir.), *cert. denied* 106 S.Ct. 77 (1985) (emphasis original). The required independent evidence must show more likely than not that "(1) the conspiracy existed; (2) the declarant and the defendant against whom the conspirator's statement is offered were members of the conspiracy;

and (3) the statement was made during the course of and in the furtherance of the objects of the conspiracy." *La-Z-Boy*, 756 F.2d at 1474 (citing *United States v. Peterson*, 611 F.2d 1313, 1330 (10th Cir. 1979), *cert. denied* 447 U.S. 905 (1980)). These criteria are not satisfied.

BCBSK also relies on Dr. Alexander's testimony regarding alleged statements made by Dr. Stan Kardatzke (an HCP representative) at a breakfast meeting of Family Physicians sometime in 1984 relative to dealing exclusively with HCP. This testimony, even if admissible, fails to raise a genuine issue of material fact as to the existence of conspiratorial conduct. The substance of her testimony regarding Dr. Kardatzke's remarks is:

> [T]he content of what he said was at least related to HMO Kansas and Health Care Plus was to try to convince us that we should not participate with Blue Cross-Blue Shield and my understanding of that is because it was financially advantageous for our group as well as other groups to participate with only one HMO and that if all of the groups, primary care groups in Wichita, were to do that that the Blue Cross-Blue Shield plan would not survive in the Wichita market.

(Tran. 27, p. 4312.) This testimony, even if credited, is not probative of the existence of the conspiratorial

conduct alleged by BCBSK. First, it lacks even a hint of any "agreement" between Family Physicians and any other physician group in Wichita supporting BCBSK's boycott claim. Further, the testimony is not probative of any "agreement" by Family Physicians to deal exclusively with HCP. Indeed, even crediting Dr. Alexander's hazy recollection as to the earliest date of the breakfast meeting (see Tran. 26, p. 4293; Tran. 27, p. 4357 ("early to mid-1984")), the meeting occurred well after Family Physicians' decision not to contract with HMOK, which was reached in the summer of *1983*. (Tran. 26, pp. 4261-62.)

Further, even assuming contrary to the evidence that Dr. Kardatzke's alleged remarks played some part in Family Physicians' decision not to contract with HMOK, Dr. Alexander's testimony does not "tend to exclude the possibility" that Family Physicians acted independently in arriving at that decision. To the contrary, the clear thrust of Dr. Alexander's testimony concerning Dr. Kardatzke's remarks is that his presentation focused on why it was to Family Physicians' independent economic advantage to deal with HCP as opposed to HMOK, and the unrebutted evidence of record establishes Family Physicians had earlier declined to participate wih HMOK because it had reached the same conclusion. (Tran. 26, pp. 4282-84.) Dr. Alexander herself confirmed that Family Physicians' decisions regarding HCP and HMOK were based on Family Physicians' independent assessment of the relative

economic merits of the competing programs. (Tran. 27, pp. 4313, 4358-59.) Thus, Dr. Alexander's testimony concerning Dr. Kardatzke's alleged remarks at the Family Physicians' breakfast meeting sometime in 1984 suggest only an effort by Dr. Kardatzke to emphasize the relative competitive merits of HCP as opposed to HMOK. That Family Physicians agreed with Dr. Kardatzke's assessment as to the competitive merits of the competing programs and declined to participate with HMOK raises no inference of conspiratorial conduct. Conduct that is as consistent with permissible competition as with illegal conspiracy does not, without more, support even an inference of conspiracy. *Matsushita*, 106 S.Ct. at 1362 n. 21; *Greater Park City Co.*, *supra*, slip op. at 3.

Nor is it of any moment, even if true, that Dr. Kardatzke opined HMOK might be "forced out" of Wichita as a result of the competitive process. The evidence is overwhelming that if HMOK was "forced out" of Wichita, it was forced out because it was a commercial failure. The antitrust laws are intended to protect competition, not individual competitors. *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977); *Natrona Service, Inc. v. Continental Oil Co.*, 598 F.2d 1294, 1297-98 (10th Cir. 1979); *see also Pac. Eng. & Prod. Co. of Nev. v. Kerr-McGee Corp.*, 551 F.2d 790, 795 (10th Cir.), *cert. denied* 434 U.S. 879 (1977) ("Antitrust legislation is concerned primarily with the health of

the competitive process, not with the individual competitor who must sink or swim in competitive enterprise.").

For these reasons, the proffered testimony of Mr. Denman and Dr. Alexander, whether viewed independently or in conjunction, is wholly insufficient to raise a genuine issue of material fact regarding BCBSK's §1 claims. Mr. Denman lacks any foundation to provide admissible testimony relating to HCP's dealings with Wichita physician groups. Dr. Alexander's testimony regarding alleged statements regarding alleged statements made by other members of Family Physicians, P.A. is inadmissible hearsay. Her testimony relating to Dr. Kardatzke's alleged statements at the Family Physicians breakfast meeting, even if considered competent, is not probative of conspiratorial conduct.

The final category of "direct evidence" of conspiracy cited by BCBSK is the Wichita Clinic meetings. These "minutes" refer to the minutes of a June 26, 1984 meeting of the Wichita Clinic executive committee attended also by HCP representatives. (Def.'s Ex. 453.) HCP's presentation at this meeting was prompted by its concern about the possible loss of the Wichita Clinic as a contracting HCP provider. (Tran. 17, pp. 2954-55.) In particular, HCP had become aware HMOK had approached the clinic concerning the creation of a stand alone HMO to market the clinic on an exclusive basis. (*Id.*) In addition, the clinic was considering possible participation in a new St.

Francis PPO at that time. (Tran. 26, pp. 4152, 4172.) The question under consideration by the Wichita Clinic executive committee at the June 26 meeting was whether the clinic would participate with HCP, HMOK, or both, as well, as new PPOs. (Tran. 26, p. 4172.) The Wichita Clinic subsequently joined the St. Francis PPO. (*Id.*, pp. 4152, 4193.) On July 10, 1984, however, the clinic's executive committee voted to terminate its contract with HMOK and to continue its HMO participation only with HCP. (*Id.*, pp. 4173-4175; Def.'s Ex. 455.

In this context, the Wichita Clinic "minutes" are not probative of conspiratorial conduct. The minutes do not evidence any agreement between the Wichita Clinic and any other physician group to "boycott" HMOK. Nor do the minutes reflect any solicitation by HCP of any binding commitment by the Wichita Clinic to refrain from doing business with HMOK. To the contrary, the minutes merely reflect HCP's effort to "sell" the clinic on the advantages of participating with HCP, and HCP's "interest" in having the clinic "participating exclusively with HCP with HMO's," an "*arrangement [which] could be broken at any time if the clinic felt it was not advantageous to do so.*" (Def.'s Ex. 453; emphasis added.) This is nothing more than competition on the merits, particularly in light of the fact HCP was responding to HMOK's own "exclusive" overtures to the Wichita Clinic. Dr. Hummer gave detailed testimony concerning the reasons why the Wichita

Clinic terminated its contract with HMOK. In essence, these reasons were: (1) HMOK paid the clinic less than HCP for essentially the same work; (2) to the extent HMOK was successful in attracting patients from HCP, the clinic's revenue stream would be adversely affected; and (3) HMOK's limited enrollment base placed the Wichita Clinic at considerable financial risk under its capitation contract. (Tran. 26, pp. 4195-97.)

Thus, the evidence demonstrates that the Wichita Clinic's decision to discontinue its contractual relationship with HMOK was based on legitimate business reasons relating to the competitive merits of HCP versus HMOK from the clinic's standpoint. Economics and common sense led the Wichita Clinic to conclude that continued participation with HMOK was a losing proposition. Under these circumstances, the fact it decided to terminate its contract with HMOK is simply no evidence of conspiratorial conduct.

Nor does BCBSK advance any facts to challenge the unrebutted testimony that the Wichita Clinic is an "exclusive" HCP provider only in the sense it has not entered into contract with any other HMOs. (Tran. 26, p. 4201.) In particular, BCBSK has not produced any evidence which calls into question the fact there is no limitation whatsoever on the clinic's ability to contract with another HMO or any other prepaid plans. (Tran. 26, p. 4201; Tran. 17, p. 2958; Tran. 25, pp. 3981-82, 4021-23.) Indeed, the unrebutted evidence shows the Wichita Clinic has

continued to negotiate with HMOK on various proposals since the summer of 1984, including a February, 1985 HMOK proposal regarding formation of a group model HMO. (Tran. 7, pp. 1142-48; Tran. 8, p. 1372; Tran. 25, p. 4056; Tran. 26, p. 4204; Def.'s Ex. 461; Pltfs.' Ex. 490.) There are simply no facts to suggest the Wichita Clinic would not presently be receptive to a good business proposal from HMOK, as BCBSK's Dauner conceded at trial (Tran. 8, p. 1392), nor that the clinic would not have continued its contractual relationship with HMOK in 1984 if the BCBSK HMO had offered an economical, viable program. Thus, even assuming the Wichita Clinic's decision to terminate its contract with HCP evidences an "agreement" to deal exclusively with HCP, the at-will nature of that "agreement" does not raise a jury-submissible issue under §1 of the Sherman Act. *See Roland Machinery Co. v. Dresser Industries*, *supra*; *Tampa Electric Co. v. Nashville Coal Co.*, *supra*.

Nor does the "circumstantial evidence" cited by BCBSK raise any genuine issue of material fact as to its §1 claims. The mere opportunity to conspire is not sufficient to support any inference of conspiracy or of participation in a conspiracy. *Weit v. Continental Illinois Bank & Trust Co.*, 641 F.2d 457, 462 (7th cir. 1981), *cert. denied* 455 U.S. 988 (1982); *Oreck Corp. v. Whirlpool Corp.*, 639 F.2d 75, 79 (2d Cir. 1980), *cert. denied* 454 U.S. 1083 (1981). Thus, the mere existence of "numerous

meetings between Dr. Kardatzke and Wichita physician groups" raises no genuine issue as to the existence of the alleged conspiracy. In contrast to the present situation, in opposition to defendant's motion for summary judgment on the complaint, plaintiffs produced evidence showing BCBSK not only met jointly with St. Francis *and* St. Joseph, but that BCBSK discussed Wesley's termination in connection with the solicitation of discounts from the Saints, the acceptance of which was contrary to their economic self-interest. In other words, plaintiffs produced evidence to show BCBSK actually seized the opportunity to conspire in restraint of trade. *Reazin I*, 635 F.Supp. at 1303-08. BCBSK can point to no such evidence in support of its counterclaim.

Likewise, the "timing of the Wichita [Clinic] and Hillside contract cancellations, . . . and the inability of HMOK to contract with key physician groups in Wichita" failed to support any inference of conspiracy. BCBSK seeks to invoke the "conscious parallelism" or the narrower "hub and spoke" theory, but the facts of record fail to support application of that theory as a matter of law. To successfully invoke "conscious parallelism" BCBSK must produce facts showing the physician groups' conduct was indeed "conscious". That is, it must produce evidence showing the medical groups were conscious of each other's conduct and that such awareness played a part in their decisionmaking process. *Theatre Enterprises v. Paramount*, 346 U.S. 537, 541

(1954); *Pan-Islamic Trade Corp. v. Exxon Corp.*, 632 F.2d 539, 559 (5th Cir. 1980), *cert. denied* 454 U.S. 927 (1981). There is no evidence that the Wichita Clinic or Hillside were "conscious" of each other's respective decision at the time of their own decisions regarding HMOK. Indeed, the evidence is to the contrary. (SMF ¶¶ 57-59.) Nor is there any evidence that such awareness, even if it existed, played any part in their individual decisions. Dr. Reazin specifically testified that the actions or intentions of other groups regarding HMOK "wouldn't have changed my mind a bit because it wouldn't have changed my numbers here . . . . We were looking at low enrollment and we made our decision based on that." (Tran. 16, pp. 2704-05.) Nor is there any evidence supporting BCBSK's allegations as to those physician groups which declined to contract with HMOK from the outset. (SMF ¶¶ 60-61.)

Further, it is well settled that even consciously parallel conduct, standing alone, will not support an inference of conspiracy. *Theatre Enterprises*, 346 U.S. at 549; *Consolidated Farmers Mut. Ins. Co. v. Anchor Savings*, 480 F.Supp. 640, 649 (D. Kan. 1979), *aff'd* 1980-2 Trade Cases (CCH) ¶63,530 (10th Cir. 1980), *cert. denied* 449 U.S. 1080 (1981); *Schoenkopf v. Brown & Williamson Tobacco Corp.*, 637 F.2d 205, 208 (3d Cir. 1980); *Modern Home Institute, Inc. v. Hartford Accid. & Indem. Co.*, 513 F.2d 102, 110 (2d Cir. 1975). Before

BCBSK can successfully invoke conscious parallelism, it must produce additional facts, or "plus" factors tending to show the actions of the medical groups were interdependent or somehow concerted. *Nat'l Auto Brokers Corp. v. General Motors Corp.*, 572 F.2d 953, 959 (2d Cir. 1978), *cert. denied* 439 U.S. 1072 (1972); *United States v. General Motors Corp.*, 1974-2 Trade Cases (CCH) ¶75,253 (E.D. Mich. 1974). At a minimum, BCBSK must also show (1) the medical groups acted in contradiction of their economic self-interest, *and* (2) they had a motive to enter into the unlawful agreement. *Schoenkopf*, 637 F.2d at 208; *Consolidated Farmers*, 480 F.Supp. at 649. Even assuming BCBSK could produce credible evidence relating to the "motive" to conspire, the unrebutted evidence demonstrates the medical groups *did not* act in contradiction of their economic self-interest. The evidence shows the exact opposite is true. (SMF ¶¶ 26-27, 43, 52-55.) Thus, BCBSK's attempt to invoke "conscious parallelism" fails as a matter of law to raise any genuine issue of material fact.

BCBSK's reliance on *Interstate Circuit, Inc. v. United States*, 306 U.S. 208 (1939), is misplaced. Here, no evidence suggests knowledge among the physician groups of a common scheme, or even that others were asked to participate, or that each knew that cooperation was essential to the plan, or that the plan would unreasonably restrain trade. Nor is there any evidence of "early awareness" or renewal.

See Interstate Circuit, 306 U.S. at 226-27. Although parallel business behavior is admissible circumstantial behavior from which the factfinder may infer agreement, proof of parallel business behavior does not conclusively establish agreement; "'conscious parallelism' has not yet read conspiracy out of the Sherman Act entirely." *Theatre Enterprises*, 346 U.S. at 538-39.

The "timing of the [HCP] stock offers and issuance" is equally devoid of any probative value as to the existence of a conspiracy. As previously discussed, even if HCP stock created an additional financial incentive to deal with HCP as opposed to HMOK, that is no more suggestive of conspiratorial conduct than is reimbursing physicians at higher capitation levels. Where, as here, two HMOs offer the same model, any financial advantages offered by one will inure to the detriment of the other relative to provider participation because, from the provider's perspective, supporting the success of the financially inferior HMO ultimately will result in "less return for essentially the same services." (See Tran. 26, pp. 4195-97.) HMOK did nothing to tip the economic balance in its favor -- neither through its own issuance of stock, higher capitation payments, or offering an alternative HMO model -- and it was therefore the loser in the competition for physician support. In any event, the unrebutted testimony elicited at trial demonstrates HCP stock played no part whatsoever in the decision of any provider regarding HMOK. (SMF ¶¶ 62-68.)

Finally, the activities of the physicians' "Consortium" provide BCBSK no support. There is no evidence the members of the Consortium actually acted in concert to "boycott" HMOK. More specifically, the Consortium did not begin meeting until the fall of 1984 at the earliest, well after the alleged events here in issue *and* subsequent to HMOK's September 5, 1984 decision to withdraw from Wichita. (Tran. 26, p. 4285; Tran. 27, p. 4376; SMF ¶31.)

Where a plaintiff's evidence of an agreement to undertake joint activity violating §1 is not indirect or ambiguous, and the evidence tends to exclude the possibility the alleged conspirators acted independently in pursuing the challenged conduct, *Matsushita* and the cases upon which it relies require defendants' motion for summary judgment be denied. *Instructional Sys. Dev. Corp. v. Aetna Cas. and Surety Co.*, No. 82-2105, slip op. at 13-15 (10th Cir. Apr. 22, 1987). But where a plaintiff's evidence of an alleged conspiracy violative of §1 is met, as here, with evidence of legitimate business reasons for defendants' conduct, that shifts to plaintiff the burden of providing evidence which tends to exclude the possibility the alleged conspirators acted independently. *Gibson v. Greater Park City Co.*, Nos. 84-1829, 84-2209, slip op. at 3, 6 (10th Cir. May 7, 1987). Where the evidence put forth by plaintiff in an attempt to meet that burden is equivocal, supporting *either* a permissible or a conspiratorial

motive, that is not evidence tending to *exclude* the possibility defendants were pursuing independent interests, and defendants' unrebutted independent plausible explanations bring such a case within the *Matsushita* test for awarding summary judgment. *Greater Park City Co., supra*, slip op. at 6-7. BCBSK has failed to provide, as *Matsushita/Greater Park City Co.* require, evidence that tends to *exclude* the possibility the alleged provider-conspirators acted independently -- a "possibility" which, as discussed above, direct testimony as established as actual *fact*.

I conclude there is no significant probative admissible evidence tending to support the §1 allegations of the counterclaim. Even resolving in BCBSK's favor the permissible inferences from its admissible evidence, that evidence fails to raise a genuine issue of material fact from which a jury could find in favor of BCBSK and HMOK on all elements of their §1 claims. Accordingly, counterclaim defendants are granted summary judgment on those claims. *Greater Park City Co., supra*.

-- §2 Claims --

BCBSK also claims counterclaim defendants violated §2 of the Sherman Act, alleging the offenses of monopolization, attempt to monopolize, and conspiracy to monopolize. To establish the offense

of monopolization, a plaintiff must prove defendant possesses "monopoly power" in a relevant market, and that such power was willfully acquired or maintained. *Instructional Sys. Dev. Corp. v. Aetna Cas. and Surety Co., supra*, slip op. at 17-18 (quoting *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1966)). "Monopoly power" is defined as "the power to control prices in the relevant market *and* exclude competition." *Shoppin' Bag of Pueblo, Inc. v. Dillon Companies*, 783 F.2d 159, 164 (10th Cir. 1986) (emphasis added).

There is no evidence any counterclaim defendant has monopoly power, thus defined, in any relevant market. BCBSK's §2 claims as to HCP rest exclusively upon Dr. Hamilton's inadmissible and defective affidavit alleging the existence of a "Wichita HMO submarket." As previously discussed, Dr. Hamilton's affidavit raises no genuine issue as to this contrived "submarket". His affidavit is inconsistent with his deposition testimony; he himself has undercut the very foundation which would now be necessary to support the allegations contained in his affidavit. As counterclaim defendants point out, the only "dispute" as to this issue, therefore, is between Dr. Hamilton today and Dr. Hamilton yesterday. As to HCP in particular, the evidence shows it lacks either power over price or power to exclude competition in the private health care financing market. Further, even crediting Dr. Hamilton's affidavit, and assuming HCP possesses

market power in this nonexistent "submarket", there is no evidence HCP possessed any purpose or intent to exercise monopoly power for anticompetitive or exclusionary purposes, an essential element of monopolization under §2. *United States v. Griffith*, 334 U.S. 100 (1948); *Volasco Products Co. v. Lloyd A. Fry Roofing Co.*, 308 F.2d 383 (6th Cir. 1962), *cert. denied* 372 U.S. 907 (1963).

At a minimum, BCBSK must show -- and it cannot -- HCP abused its monopoly power by acting "in an unreasonably exclusionary manner" relative to its competitors. *See, e.g., Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 276 (2d Cir. 1979), cert. denied 444 U.S. 1093 (1980); *Mid-Texas Communications Systems, Inc. v. American Telephone & Telegraph Co.*, 615 F.2d 1372, 1387 (5th Cir.), *cert. denied* 449 U.S. 912 (1980); *Soo Hardwoods, Inc. v. Universal Oil Products Co.*, 493 F.Supp. 76, 78 (W.D. Mich. 1980) ("It is a familiar rule of antitrust law that a competitor, even one with monopoly power, does not violate Section 2 . . . unless it engages in anticompetitive practices."). With the exception of its defective §1 claims, BCBSK can point to no allegedly exclusionary practices by HCP. HCP has been no more than a vigorous and effective competitor. BCBSK's monopolization claim as to HCP therefore fails as a matter of law, even assuming contrary to fact, HCP possesses monopoly power.

Nor is there any genuine issue of material fact as to BCBSK's remaining §2 claims. BCBSK's attempt to monopolize claim is defective because BCBSK cannot show there is a "dangerous probability" that HCP could succeed in achieving monopoly power; nor is there any evidence of a specific intent to monopolize by HCP. *Shoppin' Bag of Pueblo*, 783 F.2d at 161.

To establish a conspiracy to monopolize in violation of §2, a plaintiff must show an agreement, overt acts in furtherance of that agreement, and a specific intent to monopolize any part of interstate commerce. *Instructional Sys. Dev. Corp. v. Aetna*, *supra*, slip op. at 15. BCBSK's failure of proof as to its conspiracy claim under §1 precludes any issue of fact as to its conspiracy to monopolize claim under §2. *United States v. Yellow Cab Co.*, 332 U.S. 218 (1947); *Richter Concrete Corp. v. Hilltop Concrete Corp.*, 691 F.2d 818, 827 (6th Cir. 1982). HCP's entitlement to summary judgment on this claim is also established by the absence of any proof of a specific intent to monopolize. *Pac. Eng. & Prod. Co. v. Kerr-McGee Corp.*, 551 F.2d 790 (10th Cir.), *cert. denied* 434 U.S. 879 (1977).

The foregoing principles are also dispositive of BCBSK's §2 allegations against Wesley and HCA. There is simply no evidence of any exclusionary conduct or specific intent to monopolize on the part of either Wesley or HCA. Thus, BCBSK's §2 claims against those parties fail as a matter of law, even

assuming, contrary to fact, that Wesley and/or HCA are "dominant" factors in any relevant market. There is no evidence either Wesley or HCA *did anything* anticompetitive, exclusionary, or even remotely suspect with respect to BCBSK or anyone else.

BCBSK finds much comfort in the testimony of its own employees that on July 24, 1985, at the meeting regarding Wesley's participation in the Choice Care PPO, Edmund Berry allegedly stated "'it was HCA's intention to put one of the other large hospitals in Wichita out of business and then work with the other hospital.'" (Tran. 7, pp. 1193-94.) As evidence of allegedly unlawful specific intent, however, this is inadequate to lend support to BCBSK's §2 claims. "Whether a particular employee's intent may be attributable to the company [for these purposes] depends on the employee's role in the decisional process of the company." *Instructional Sys. Dev. Corp. v. Aetna*, *supra*, slip op. at 16 n. 4 (citing VII P. Areeda, Antitrust Law ¶1506 (1986)). In *Aetna*, defendant Doron's national sales manager stated "his goal" was to put plaintiff ISDC out of business. The manager reported to Doron's president, and the Tenth Circuit held "[t]his and other evidence clearly permits a factfinder to infer that Doron and Aetna made joint decisions, pursuant to the contract and outside it, which furthered Doron's goal of driving ISDC out of business." *Id.*, slip op. at 16. If a company can be bound to statements of an employee's *personal* intent

by virtue of his role in the decisionmaking process of the company, it is equally appropriate to examine that same relationship to determine whether a company is bound to an employee's statements regarding *company* intent. Mr. Berry is a senior vice president and financial officer of Wesley. (Tran. 2, p. 251.) He is responsible for preparing financial statements and budgets, monitoring accounts receivable and presenting financial information to the hospital's board of trustees. (Tran. 16, p. 2798.) Mr. Berry's responsibility in connection with Wesley's relations with third-party payors (insurance companies) is to provide support to Senior Vice President Robert O'Brien in O'Brien's role as chief negotiator of contracts. (*Id.*; Tran. 2, p. 251.) Mr. Donald Stewart, Wesley's president, also participates in these negotiations from his policy perspective as chief operating officer. (Tran. 2, p. 252.) Mr. Berry's participation was limited to providing supporting financial data; he lacked full negotiating authority. (Tran. 2, pp. 252-53; Tran. 16, pp. 2798-99, 2817.) Mr. Berry's notes following the July 24 meeting and his observations and recommendations on the Choice Care contract (Def.'s Ex. 272) were circulated to Robert O'Brien and other Wesley administrative officials, but were never acted upon or implemented. (Tran. 17, pp. 2833-41.) Neither Berry nor anyone else from Wesley discussed the Choice Care contract with HCA officials in Nashville or Dallas (the regional office), either before or after

the July 24 meeting. (*Id.*, pp. 2843-44, 2845-46, 2849-50.) Mr. Berry was not involved in the earlier decisionmaking process which led Wesley to contact HCA about the possible sale of the hospital; he was informed after the fact and simply provided financial data for Wesley's use in the negotiations. (Tran. 16, pp. 2800-02.) Finally, Mr. Berry was not involved in any way with HCA's acquisition of HCP. (*Id.*, p. 2803.) Mr. Berry no doubt serves an important function in the administration of Wesley, but in the face of this evidence it cannot be argued he plays a role in the *policy* decisionmaking processes of the hospital, let alone those of HCA.

But even crediting BCBSK's version of his statement, it does not support any jury-submissible issue regarding specific intent to monopolize. Assuming *arguendo* it was HCA's intention to "force" another Wichita hospital out of business, Berry's alleged remark does not suggest the contemplated use of anticompetitive means to achieve that result. As the Tenth Circuit observed in *Pac. Eng. & Prod. Co.*, 551 F.2d at 795:

> "[A] person does not have an exclusionary intent merely because he foresees that a market is only large enough to permit one successful enterprise, and intends that his enterprise shall be that one and that all other enterprises shall fail. . . . To prove that a person has that type of exclusionary intent which is condemned in

> anti-trust cases, there must be evidence that the person who foresees a fight to the death intends to use or actually does use unfair weapons . . ."

(quoting *Union Leader Corp. v. Newspapers of New England, Inc.*, 180 F.Supp. 125, 140 (D. Mass. 1959), *modified* 284 F.2d 582 (1st Cir. 1960), *cert. denied* 365 U.S. 833 (1961)). Thus, Mr. Berry's comment, even assuming it was made, does not counter the total absence of any anticompetitive conduct -- actual or intended -- by Wesley or HCA, nor is it sufficient to raise a genuine issue of fact as to specific intent to monopolize.

Counterclaim defendants are granted summary judgment on BCBSK's §2 claims.

-- §7 of the Clayton Act --

BCBSK next alleges HCA's acquisition of Wesley, HCP and New Century violates §7 of the Clayton Act, which prohibits acquisitions "the effect of [which] may be substantially to lessen competition, or tend to create a monopoly." 15 U.S.C. §18. On its face, BCBSK's §7 claim fails to state a cause of action against counterclaim defendant Reazin. The corporate counterclaim defendants are entitled to summary judgment on the §7 claim because BCBSK has advanced no evidence that HCA's acquisitions of Wesley, HCP or New Century, individually or as a group, will "substantially lessen competition" in

violation of that statute.

Vertical integration is not an unlawful or even suspect category under the antitrust laws. *Jack Walters & Sons Corp. v. Morton Building, Inc.*, 737 F.2d 698, 710 (7th Cir. 1984). Consequently, vertical mergers will not be condemned under §7 in the absence of facts tending to show the merger will result in a foreclosure of access to sources of supply, a significant increase in concentration in a relevant market, or heightened barriers to entry in either market. *See Ford Motor Co. v. United States*, 405 U.S. 562 (1972). The mere possibility a merger might have anticompetitive effects does not satisfy the statutory requirement of §7. *United States v. E. I. du Pont de Nemours & Co.*, 353 U.S. 586, 590-93 (1957). Rather, to avoid summary judgment it is a plaintiff's burden to produce evidence which shows a reasonable probability that anticompetitive effects will, in fact, occur. *Brown Shoe Co. v. United States*, 370 U.S. 294, 323 (1962); *United States v. First Nat'l Bank of Maryland*, 310 F.Supp. 157, 161 (D. Md. 1970).

HCA's acquisitions do not create any actual or probable horizontal anticompetitive effects. The undisputed facts demonstrate HCA's acquisitions of Wesley and HCP have resulted in no structural changes in the hospital services or health care financing markets in Wichita. Prior to Wesley's acquisition, there were four independently owned hospitals in Wichita; today all four of those hospitals

are still operating independently. If anything, Wesley -- the largest hospital both before and after the acquisition -- has lost market share following its affiliation with HCA. (Tran. 23, pp. 3860-61; Pltfs.' Ex. 507-A.) Similarly, the acquisition of HCP did not result in a reduction in the number of health care financing entities doing business in Wichita; in fact, that number has increased since the acquisition with the reintroduction of BCBSK's HMO through Kansas Health Plans, the reintroduction of Choice Care, and the commencement of St. Francis' PPO. (Tran. 8, pp. 1336-38; Tran. 11, pp. 1907-08; Tran. 14, pp. 2316-17.) BCBSK's own expert, Dr. Christianson, conceded HCA's acquisitions did not change the structure of the market in Wichita; HCA simply seized a unique opportunity. (Tran. 28, pp. 4605-06.) Thus, it is undisputed there has been no increase in concentration in either market as a result of HCA's acquisitions.

BCBSK's next suggestion, that HCA's acquisition of Wesley will somehow drive one of the other hospitals in Wichita out of business, is rank speculation. The excess capacity that exists in the hospital services market in Wichita predated the HCA acquisition by several years, as did the speculation in the medical community that one of the hospitals might not survive; neither says anything about HCA's intentions in entering the Wichita market. There is no evidence in the record HCA's acquisition of Wesley has in any way exacerbated the situation. That Wesley sought a buyer with

significant resources to ensure its future competitive viability is not illegal. Wesley's competitors lacked "the share, strength and resources of Wesley" prior to the acquisition, not as a result of it. In fact, Wesley's competitors have gained market share vis-a-vis Wesley since the acquisition -- clear proof the acquisition is not likely to have the anticompetitive effects posited by BCBSK.

Equally lacking merit is BCBSK's argument HCA's acquisitions eliminated a potential entrant. There is no record evidence HCA had any inclination to enter the Wichita hospital services or health care financing markets until it was approached by Wesley and HCP. (SMF ¶¶ 70, 71.) HCA certainly did not abandon plans to construct a new hospital or establish a new HMO in Wichita when these opportunities arose. BCBSK's references to internal position papers prepared by Wesley prior to its approach to HCA are not probative of *HCA*'s intent; even if they were, however, they establish nothing more than the possibility an investor-owned chain might enter the Wichita market by purchasing a hospital. This is precisely the type of entry which in fact occurred, but it does not demonstrate the likelihood of *de novo* entry -- by constructing a hospital -- which is required under the potential entrant doctrine. *FTC v. Atlantic Richfield Co.*, 549 F.2d 289, 294-95 (4th Cir. 1977) ("clear proof" that acquiring firm would in fact have entered the relevant market is required).

Finally, the contention HCA's acquisition of HCP somehow "solidified" the alleged conspiracy to boycott HMOK is clearly unfounded. Even if such a conspiracy existed (contrary to the evidence), HCA's purchase of HCP dissipated rather than "cemented" the ties between physicians and HCP by eliminating the stock ownership which, according to BCBSK itself, created the motivation for the "boycott". There is no evidence in the record, then, that even tends to suggest HCA's acquisition of HCP will make it more difficult for competing HMOs to contract with providers, including Wesley. Indeed, Wesley has had, and continues to have, a contract with HMOK. (SMF ¶82.)

BCBSK has failed to present any evidence it has suffered antitrust injury as a result of HCA's acquisitions of Wesley and HCP. That these acquisitions may make Wesley and HCP more formidable competitors does not constitute antitrust injury to BCBSK. *See Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477 (1977).

BCBSK's argument regarding the likely anticompetitive effects of HCA's vertical integration in the Wichita market is premised on the notion HCA's purchases of Wesley and HCP created a "closed, fully integrated system." This argument is contrary to the evidence, and the law.

The undisputed evidence shows Wesley is still a participant (and wishes to continue to participate) in BCBSK's CAP program and HMOK. (SMF ¶¶ 81-82.) Similarly, HCP maintains contracts with all

of the hospitals in Wichita. In fact, prior to HCP's sale to HCA, HCP sought and received assurances from HCA that it would not be required to deal solely with Wesley after the acquisition, and the evidence conclusively demonstrates this has been the case. (Tran. 17, pp. 2968-70.) Thus, there is no evidence of the actual or probable market foreclosure that is the harm which Dr. Christianson imagined could possibly occur from the creation of a closed system. The capitation agreement between Wesley and HCP was signed long before the integrated system allegedly created by HCA's acquisitions was even conceived. (SMF ¶75.) The purported "channeling mechanisms" of HCA were fully explored at trial, and it is clear on the record no such mechanisms are in place, or are even under consideration, in Wichita. (SMF ¶¶ 79-80.)

The absence of any actual or probable market foreclosure also distinguishes this case from the vertical integration cases relied upon by BCBSK. As BCBSK concedes, vertically integrated systems are not a concern per se; it is only when the vertical integration produces probable or actual anticompetitive effects of a substantial nature that §7 is implicated. In this case, despite HCA's "track record" of almost two years, BCBSK is unable to identify any such actual or probable anticompetitive effects, much less any injury to BCBSK, arising out of HCA's acquisitions.

The contention these acquisitions somehow raised the barriers to entry in the health care

services or health care financing markets is similarly without foundation. The only evidence in the record -- other than Dr. Christianson's speculation -- is that at least three vertically integrated competitors *have* entered the market since the acquisition: HMO Kansas re-entered the market through Kansas Health Plans; BCBSK has reestablished its Choice Care PPO; and St. Francis established its own PPO. (SMF ¶¶ 85-86.) Not only is there no evidence that entry barriers have been raised, but Dr. Christianson's assumption the payment of "premium prices" for Wesley and HCP will deter entry by vertically integrated competitors is legally and logically suspect. As the Court noted in *Missouri Portland Cement Co. v. Cargill, Inc.*, 498 F.2d 851, 866 n. 32 (2d Cir.), *cert. denied* 419 U.S. 883 (1974), "mere recitation of the 'deep pocket' shibboleth [is] not enough" to establish a §7 violation. BCBSK fails to produce any evidence demonstrating *how* the presence of a "deep pocket" company in the Wichita market will increase barriers to entry. This failure of proof distinguishes the instant case from *Kennecott Copper Corp. v. FTC*, 467 F.2d 67 (10th Cir. 1972), *cert. denied* 419 U.S. 909 (1974), where the Court approved the FTC's finding Kennecott would use its "deep pocket" to acquire vast coal reserves and compete for long-term utility supply contracts, thus gaining new market share and increasing concentration in the market. Even assuming *arguendo* HCA did pay substantially more for Wesley

and HCP than their "true values", that would not increase the cost of entry for an integrated competitor. BCBSK's speculation that other vertically integrated competitors might view opportunities in other geographical markets to be more attractive than Wichita, does not demonstrate that HCA's acquisitions have had, or will have, any anticompetitive effects in Wichita; to the contrary, it demonstrates the highly competitive nature of the hospital services market in Wichita.

In conclusion, the undisputed record demonstrates nothing more than that HCA purchased the largest hospital and the only existing HMO in Wichita in 1985, and since that time Wesley has lost market share and BCBSK has introduced new programs in Wichita in competition with HCP to Choice Care and Kansas Health Plans. Lacking any evidence of actual or probable anticompetitive effects (or antitrust injury), BCBSK has utterly failed to sustain its burden of proof under §7. In fact, the evidence of record demonstrates, with the exception of BCBSK's own unlawful conduct, that the acquisitions in question have neither occasioned nor threatened any anticompetitive consequences.

Counterclaim defendants are therefore entitled to summary judgment on BCBSK's §7 claims.

-- State Tort Claims --

The last two counts of BCBSK's counterclaim allege HCP interfered with BCBSK's prospective advantage and contractual relations by causing Hillside Medical Office and Wichita Clinic to terminate their agreements with HMOK. Counterclaim ¶¶ 31, 32. There is no issue whatsoever as to these claims as they relate to Hillside Medical Office, because the evidence demonstrates HCP did not interfere with Hillside's relations with HMOK in any manner. Hillside's decision to terminate its contract with HMOK was made independently, without any input from HCP or any other third party. Nor can BCBSK's tort claims relating to the Wichita Clinic survive this motion for summary judgment.

It is fundamental that the tort of interference with contractual relations requires proof HCP induced Wichita Clinic to *breach* its contract with HMOK. *Professional Investors Life Ins. Co. v. Roussel*, 528 F.Supp. 391, 397 (D. Kan. 1981); *see also Prudential Ins. Co. of Amer. v. Sipula*, 776 F.2d 157, 162 (7th Cir. 1985). The contract between Wichita Clinic and HMOK, however, was terminable at will upon 30 days' notice, and the Wichita Clinic therefore committed no breach by terminating the contract in accordance with its terms.

Further, it is well settled under Kansas law that not all interference in present or future contractual

relations is tortious. *Turner v. Halliburton Co.*, 240 Kan. 1, 12, 722 P.2d 1106, 1115 (1986). Rather, a necessary predicate for both causes of action is "malice". *Turner*, 240 Kan. at 12-13. Malice is defined as "intentional interference without justification." Restatement (Second) of Torts §766 comment s (1979); *see also May v. Santa Fe Trail Transp. Co.*, 189 Kan. 419, 370 P.2d 390 (1962) ("While it is true that an action will lie for unjustifiably inducing a breach of contract by a party thereto, the inducement must be wrongful and not privileged.").

One's privilege to engage in business and to compete with others implies a privilege to induce third persons to do their business with him rather than with his competitors. Restatement (Second) of Torts §768 comment b (1979); *see also Prudential Ins. Co.*, 776 F.2d at 162-63 ("lawful competition . . . constitutes a privileged interference with another's business"). Consequently, no tort is committed by a competitor who causes a third person not to enter into a prospective contractual relation, or not to continue in existing contracts terminable at will, so long as the actor does not employ improper means and his purpose is at least in part to advance his interest in competing with the other. Restatement (Second) of Torts §768 (1979).

It is clear HCP's discussions with the Wichita Clinic regarding a possible "exclusive arrangement" were made to advance HCP's competitive interests

vis-a-vis HMOK; indeed, the discussions in 1984 were prompted by HMOK's own overtures regarding an exclusive arrangement with that group.

Nor is there any evidence to suggest HCP engaged in fraud, coercion, or any other arguably wrongful or illegal means in an effort to convince the Wichita Clinic (or any other group for that matter) to deal "exclusively" with HCP -- yet another failure of proof distinguishing BCBSK's claims of tortious interference from those of plaintiff Wesley. At most, the evidence shows HCP sought to persuade the Wichita Clinic that it was in the clinic's best interest to continue to deal with HCP. Persuasion, however, is not wrongful, and such efforts do not support a claim for tortious interference. Restatement (Second) of Torts §770 comment d (1979).

Counterclaim defendant HCP is granted summary judgment on BCBSK's claims of tortious interference with prospective advantage and contractual relations.

-- Counterclaim --

To avoid summary judgment under Rule 56 requires the nonmoving party to demonstrate the existence of genuine issues of material fact. The massive record before the court portrays not anticompetitive conduct by counterclaim defendants, but competition and BCBSK's fear of competition. In 1984, HMOK lost the competitive contest to HCP;

HCP was able to persuade medical groups to do business with it, often at the expense of HMOK, by offering a better product: more patients, an acceptable risk level, more profits, and the possibility of future equity returns as to the limited number of physicians who purchased the stock. HMOK failed to respond effectively and voluntarily decided to withdraw from the marketplace. In 1985, HCA acquired Wesley and HCP, acquisitions which left the number of Wichita hospitals and health care financing organizations unchanged. The structure of neither market was altered. BCBSK, however, became frightened because it perceived the arrival of even more effective competition.

BCBSK's litany of "conspiracy", "force-out", "lock-up", "payoff", and the like, unsupported by probative admissible evidence does not alter these truths. I read the Tenth Circuit's recent decision in *Gibson v. Greater Park City Co., supra*, with no small sense of *déja vu*. Plaintiffs Gibson, et al., pursued an approach to their antitrust allegations striking in its similarity to the approach undertaken by BCBSK in this case. BCBSK has seized on a plethora of "facts", isolating and attributing to each a conspiratorial motive, as did plaintiff Gibson. Gibson's evidence was ambiguous because respondents Greater Park City Co., et al., offered plausible nonconspiratorial explanations for each action about which he complained. BCBSK's evidence in this case is, at best, equally ambiguous because the counterclaim defendants have done the

same. Plaintiff Gibson was unable to respond with evidence tending to exclude the possibility the alleged conspirators acted independently, and his antitrust complaint was summarily judged and dismissed. *Greater Park City Co.*, *supra*, slip op. at 6-7. BCBSK has likewise failed in this case, and summary judgment is, for the same reasons, required.

Counterclaim defendants' motion for summary judgment is sustained in its entirety.

EPILOGUE

Reviewing the evidence and testimony relating to both the complaint and counterclaim, the quintessence is this: for the first time in its corporate existence Blue Cross and Blue Shield of Kansas faces vigorous, efficient, well-managed, and effective price and product competition, attracting the attention and business of Kansas consumers of health care financing products. The allegations in the counterclaim are unsupported; Blue Cross and Blue Shield of Kansas, and HMO Kansas, suffered no anticompetitive, illegal or remotely impermissible competition from Hospital Corporation of America, Health Care Plus, or Wesley Medical Center. After hearing the evidence on plaintiffs' complaint, the jury found Blue Cross and Blue Shield chose to react to this competition not on the merits of its own products but in a manner violating federal antitrust and state laws, injuring the very consumers defendant professes to serve, competition in the

market for health care financing products, and plaintiff Wesley Medical Center. That verdict is supported by prevailing law and abundant evidence, and will not be disturbed. Therefore, in order to restore the rights of Kansas consumers, the competition in the relevant market, and the respective positions of the parties required by law:

IT IS ACCORDINGLY ORDERED this *22* day of May, 1987, the motion of defendant Blue Cross and Blue Shield of Kansas, Inc., to set aside the jury's verdict and dismiss this case for lack of jurisdiction under the McCarran-Ferguson Act is *overruled*.

IT IS FURTHER ORDERED defendant's motions for directed verdict, taken under advisement during trial and at the close of evidence, are *overruled*.

IT IS FURTHER ORDERED defendant's motion for judgment notwithstanding the verdict or alternatively for a new trial is *overruled*.

IT IS FURTHER ORDERED that judgment this day is entered upon the jury's verdict of September 30, 1986, in favor of plaintiff HCA Health Services of Kansas, Inc., d/b/a Wesley Medical Center, against defendant Blue Cross and Blue Shield of Kansas, Inc., in the amount of $5,378,941.00, representing trebled actual antitrust damages in the amount of $4,628,940.00, actual nominal damages of $1.00, and punitive damages of $750,000.00. Interest thereon shall be calculated

from May 22, 1987, the date of the entry of judgment. 28 U.S.C. §1961.

IT IS FURTHER ORDERED the motion of plaintiffs Walter L. Reazin, M.D., HCA Health Services of Kansas, Inc., d/b/a Wesley Medical Center, Health Care Plus, Inc., and New Century Life Insurance Company for injunctive relief against defendant Blue Cross and Blue Shield of Kansas, Inc., is *overruled*.

IT IS FURTHER ORDERED plaintiffs' application for an award of attorneys' fees and costs through September 30, 1986, in the combined amount of $2,423,828.74, consisting of attorneys' fees of $2,176,983.75, expert witness fees and other reimbursable items of $209,767.77, and allowable costs of $37,077.22, is *granted* against defendant Blue Cross and Blue Shield of Kansas, Inc.

IT IS FURTHER ORDERED plaintiffs are hereby granted 30 days to file application, with supporting records and affidavits, for an award of attorneys' fees and costs representing services associated with their complaint provided after September 30, 1986. Defendant is provided 10 days thereafter to respond in writing.

IT IS FURTHER ORDERED the motion of counterclaim defendants Walter L. Reazin, M.D., HCA Health Services of Kansas, Inc., d/b/a Wesley Medical Center, Health Care Plus, Inc., New Century Life Insurance Company, and Hospital Corporation of America for summary judgment on the counterclaim of Blue Cross and Blue Shield of

Kansas, Inc., and HMO Kansas, Inc., is *sustained*. The counterclaim is dismissed with prejudice in its entirety.

Patrick F. Kelly, Judge

FOOTNOTE REFERENCES

1/ Section 1 of the Sherman Antitrust Act, 15 U.S.C. §1, provides:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade among the several States . . . is declared to be illegal . . . .

Section 2 of the Act, 15 U.S.C. §2, states:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, . . . shall be deemed [to have violated the law]. . . .

Section 4 of the Clayton Act authorizes civil antitrust suits:

> Any person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefor in any district court of the United States in the district in which defendant resides . . . without respect to the amount in controversy, and shall recover threefold the damages by him sustained, and the cost

> of the suit, including a reasonable attorney's fee.

Section 16 of the Clayton Act, 15 U.S.C. §26, authorizes private suits for injunctive relief:

> Any person, firm, corporation, or association shall be entitled to sue for and have injunctive relief, in any court of the United States having jurisdiction over the parties, against threatened loss or damage by a violation of the antitrust laws. . . .

2/ Hereafter "Tran. [x]" refers to the record and volume number of the proceedings during trial; transcripts of all other proceedings will be specifically identified.

3/ Interwoven among a number of BCBSK's present arguments is the assertion this court somehow "coerced" defendant into suspending Wesley's termination pending trial. The transcript of the November 21, 1985 proceeding belies this accusation:

> THE COURT: . . . [W]hat is your suggestion as to what we might do between now and the first of the year? You agree that you might be well advised to have the issue adjudicated in advance of January 1 and if you're wrong, at least know it first or up front?
>
> MR. SHULMAN: Your Honor, we are pleased

to have the issue adjudicated whenever it is convenient for the Court. Our concerns -- and whether that is before the first of the year or after, we'll defer to the Court on that.

THE COURT: Would you sit still to maintain your present status until it is adjudicated?

MR. SHULMAN: *We have discussed that, Your Honor, and I believe we would be willing to do that* because we are -- assuming, as I'm sure the Court is interested in doing, that the matter is adjudicated promptly. We have two real concerns procedural [sic], Your Honor: First is that we have an opportunity to present as fully as possible our side of the matter.

THE COURT: You will have that. You may be assured of it.

MR. SHULMAN: Okay.

THE COURT: I'm giving credence to the plaintiffs' claim. If I gave them full credence and acquiesced in what they said, seems to me that Blue Cross is in some trouble if that's what they are going to do and they did violate the [Sherman] Act. That's not to acquiesce in a thing they have said.

MR. SHULMAN: If we violated the Act, Your Honor, I agree with you.

THE COURT: . . . What they have asked is some kind of preliminary injunction. Would it make more sense that if we agree in principle to the substantive issues here, that perhaps Blue Cross would continue as presently operating pending full hearing on the issue as if we could take all the time we need on it and get an opinion out and then one side or the other can take me to the Circuit and see where we are. Would that make more sense?

MR. SHULMAN: I think we would be willing to do that, Your Honor, assuming that the matter does move ahead reasonably promptly.

THE COURT: If we agree to that in principle, I can put you on stream to the satisfaction of everybody what time you might need for what discovery you need, but sounds to me you pretty much would agree in principle at least to what the issues are.

MR. SHULMAN: Yes.

THE COURT: Be more of a legal argument as to where we are, wouldn't it?

MR. SHULMAN: Yes. There are some factual issues, Your Honor . . . .

. . . .

MR. DUNCAN: I don't have any problem with that, Your Honor. Sounds like a good solution to me. . . .

. . . .

THE COURT: [It] makes sense to me that both sides would be well advised to proceed this way. I don't see any harm done to Blue Cross to [have the contract] remain in effect and I would be happy to take the blame in the sense that I could enter some kind of a brief order that we have conferred, this is in the best interest of the parties that the present contract remain in effect pending hearing on the issue and give you assurance I will do it as readily as we can and you guys tells me what that time should be. What do you think?

MR. SHULMAN: *I think that is fine as long as it's clear that it is a matter of voluntary agreement of the parties.*

THE COURT: Sure. Sure. Wouldn't be as if I put it on you. . . .

(Dkt. 274, Tran. of In-Chambers Proceeding Nov. 21, 1985, pp. 9-13; emphasis added.)

4/ Section 7 of the Clayton Antitrust Act, 15 U.S.C. §18, provides in pertinent part:

> No corporation engaged in commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no corporation subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another corporation engaged also in commerce, where in any line of commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.

Violation of this statute supports a private cause of action for money damages. *Gottesman v. General Motors Corp.*, 414 F.2d 956 (2d Cir. 1969); *see also Highland Supply Corp. v. Reynolds Metals Co.*, 327 F.2d 725 (8th Cir. 1964) (private right of action exists only where acquisition has demonstrable anticompetitive effects).

5/ In addressing the issues of standing at the summary judgment stage, I noted the following:

> Particular attention must be given to defendant's argument HCP's damages, as well as those of New Century and Reazin, are "speculative". The case is presently before the Court in a unique posture because of the

> parties' voluntary agreement to preserve the status quo, continuing to abide by the terms of the Wesley/BCBSK contracting provider agreement pending the outcome of this suit. The Court perceives the case as primarily a declaratory judgment action which will be tried to the jury to determine whether what is now the proposed termination of Wesley's contract, along with the formation and effect of the revised BCBSK contracting provider agreements with the remaining Wichita hospitals, would violate the antitrust laws if carried out. To that extent all plaintiffs' claimed injuries and damages are "speculative", but of course BCBSK cannot make any such argument. Consistent with the manner in which this case [is postured and] will be presented to the jury, the Court looks not to the existing situation to determine the merit of plaintiffs' claimed damages, but to their merit if BCBSK were to carry out its allegedly anticompetitive conduct.

Reazin v. Blue Cross & Blue Shield of Kansas, Inc., 635 F.Supp. 1287, 1316-17 (D. Kan. 1986). Recognizing the procedural impact of the unusual posture of this case is *critical*, as will be discussed *infra*, because one of defendant's present challenges to the verdict is the alleged impropriety of the jury basing its decision in part upon "likely future

competitive effects" of defendant's activities in the market.

6/ 15 U.S.C. §1011 states:

> Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

7/ 15 U.S.C. §1012 states:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, . . . the Sherman Act, and . . . the Clayton Act, and . . . the Federal Trade Commission Act, as amended, shall be applicable to the business of

insurance to the extent that such business is not regulated by State law.

8/ 15 U.S.C. §1013(b) states:

> Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce or intimidate, or act of boycott, coercion or intimidation.

9/ Jury Instruction No. 37 stated:

> The second component of the relevant market, the product market, includes reasonably interchangeable services or products, that is, products or services which may be substitutes for the identical products or services in question, but only if such substitutes are actually competitive with the products or services in question. You are instructed that the relevant product market in this case is private health care financing, within the relevant geographic market as you define it according to the previous instruction.

10/ *See also SEC v. Variable Annuity Life Ins. Co. of America*, 359 U.S. 65 (1969) (variable annuity

contracts sold by life insurance companies are not "insurance" under the McCarran Act because the insurance companies do not underwrite risks); *U.S. v. Title Insurance Rating Bureau of Arizona*, 700 F.2d 1247 (9th Cir. 1983), *cert. denied* 467 U.S. 1240 (1984) (escrow services by insurers not the "business of insurance").

11/ The *Ray* court went on to note defendant insurance company's threat to terminate plaintiff's agency constituted "coercion" under §3(b). 430 F.Supp. at 1358. This was simply an additional observation by the court, unnecessary to its actual holding in light of defendant's failure to prove the conduct at issue was the "business of insurance" under §2(b).

12/ *See also Malley-Duff & Associates v. Crown Life Ins. Co.*, 734 F.2d 133, 144 (3d Cir.), *cert. denied* 469 U.S. 1072 (1984); *Professional Adjusting Systems of America, Inc. v. General Adjustment Bureau, Inc.*, 64 F.R.D. 35 (S.D. N.Y. 1974); *Monarch Life Ins. Co. v. Loyal Protective Life Ins. Co.*, 326 F.2d 841 (2d. Cir. 1963), *cert. denied* 376 U.S. 952 (1964); *California League of Independent Ins. Producers v. Aetna Cas. & Sur. Co.*, 179 F.Supp. 65 (N.D. Cal. 1959); and *Professional & Business men's Life Ins. Co. v. Bankers Life Co.*, 163 F.Supp. 274 (D. Mont. 1958).

Even before the Supreme Court's decision in *Barry*, those courts which narrowly construed the §3(b) exception recognized restraints of trade in an insurance market were actionable under federal antitrust laws by injured competitors in that market. *See Addrisi v. Equitable Life Assur. Society of U.S.*, 503 F.2d 725 (9th Cir. 1974), *cert. denied* 420 U.S. 929 (1975); *McIlhenny v. American Title Ins. Co.*, 418 F.Supp. 364 E.D. Pa. 1976), *Meicler v. Aetna Cas. & Sur. Co.*, 372 F.Supp. 509 (S.D. Tex. 1974), *aff'd* 506 F.2d 732 (5th Cir. 1975); and *Transnational Ins. Co. v. Rosenlund*, 261 F.Supp. 12 (D. Ore. 1966). *Barry* rejected this narrow "blacklisting" interpretation of §3(b), holding the protections afforded by that exception are not limited solely to companies or persons engaged in insurance. 438 U.S. at 550-52. The Court thus *expanded* the class of potential plaintiffs entitled to recover for anticompetitive activities affecting an insurance market; nowhere has the Court ever intimated that federal preservation of competition in an insurance market is foreclosed by the McCarran-Ferguson Act.

13/ One of these communications from defense counsel submits, for my consideration, a self-serving denigration of *Reazin I* by a lawyer representing another Blue Cross and Blue Shield plan not involved in this case. This person concludes his "analysis" by suggesting (or hoping) "it is doubtful that many courts will cite *Reazin* [I] for its legal

analysis . . . . " Of course, how my opinions applying the law to the facts of this case are treated by courts addressing different facts in other cases is not my immediate concern.

14/ See n. 3, *supra*.

15/ See n. 5, *supra*.

16/ The additional factual distinctions between this case and *Ball Memorial* cannot be overemphasized. BCI kept its traditional indemnity insurance plan on the market, and simply attempted to introduce a *new* PPO, making it available to *all* competing providers on a bid basis. 784 F.2d at 1331, 1341. Plaintiffs in that case were attempting to *prevent* this from coming about. The district court's conclusion BCI possessed no market power was based in part on its finding Indiana hospitals "'are *vertically integrating* into the health care financing market.'" 748 F.2d at 1332 (quoting 603 F.Supp. at 1082 (emphasis added)). "[T]he Blues have not insisted that hospitals in the Blues' PPO refrain from joining other PPOs, *so rivals have access to the hospitals on the same basis as the Blues*." 748 F.2d at 1339 (emphasis added). By distinct contrast, this case concerns BCBSK's attempts to *prevent* vertical integration in Kansas; plaintiffs alleged and the jury found, that as a direct consequence, rivals do *not* have access to Kansas hospitals on the same basis as BCBSK.

One frightening aspect of *Ball Memorial*, as I view the facts of this case, is that in selecting providers for its PPO (which, again, was open to *all* hospitals on a bid basis), BCI unequivocally *rejected* one hospital's bid of a 20% discount from its normal charges:

> The Blues excluded St. Joseph's Hospital of Ft. Wayne for two reasons -- they deemed its bid of 80% of prior prices a "low-ball" that was sure to be increased, and they concluded that it was not as conveniently located as Parkview Hospital in the same city.

748 F.2d at 1342. The Seventh Circuit interpreted the state enabling act to deny any right to discriminate on the basis of geography, but to require simply that any PPO "must not 'unreasonably discriminate' among hospitals." *Id.* The court then found there had been no unreasonable discrimination on price:

> The Hospitals do not disagree with the Blues' contention that they determined St. Joseph's bid to be a low-ball quote, too low to be justified by its costs (on which the Blues had data) and therefore too low to be sustained. One witness testified without contradiction that St. Joseph's bid was well

> below that of any other hospital, and another testified that the Blues feared that "at the first opportune time [St. Joseph's] would be asking for an unreasonably high increase." . . .

748 F.2d at 1343.

BCI's determination, in the exercise of its sound business judgment, that a 20% discount was economically unsound and unsustainable, casts a disturbing light on BCBSK's eager *request* for a *25%* discount from the Saints in Wichita, the hospitals' willing agreement to a *20%* discount (*see, e.g.*, Pltfs.' Ex. 4, *infra*), and defendant's pious assertion this "new PPO" operates to the unqualified benefit of Kansas consumers of health care financing products.

17/ On its merits, defendant's contention Wesley lacks §1 standing must be rejected out of hand. *Reazin I* analyzed and applied antitrust standing concepts to HCP, New Century and Dr. Reazin, concluding HCP was the only one of those three plaintiffs with standing to pursue actual antitrust damages under §4 of the Clayton Act. 635 F.Supp. at 1310-18. Wesley is certainly the "victim of the forbidden practices" by defendant, suffering tangible economic injury as a consequence. *Blue Shield of Virginia v. McCready*, 457 U.S. 465, 472, 475 n. 11 (1982). BCBSK recognized Wesley as a "competitor"

by virtue of its association with HCA and HCP; that is the precise reason defendant undertook the conduct at issue in this case. The harm to Wesley "was clearly foreseeable; indeed, it was a necessary step in effecting the ends of the . . . illegal conspiracy." *McCready*, 457 U.S. at 479. In fact, BCBSK's specific intent to harm Wesley may well be "dispositive" in creating standing to sue under §4. *Assoc. General Contractors v. Cal. State Council of Carpenters*, 459 U.S. 519, 537 n. 35 (1983). Wesley's injury, as a "direct victim" of defendant's coercion, vests the hospital with the right to maintain its action for treble damages. *Assoc. General Contractors*, 459 U.S. at 542.

18/ The court, in addressing the jury, stated at pp. 33-38 of the JQRP:

I needn't tell you of the time that was expended here in a trial of this case, some seven weeks. You would know out of hand that to try it was a rather expensive venture for both of these sides. More than that, an expenditure of considerable engergies [sic] and talent by these persons, but also your own and mine in hearing this case. I can tell you that from what I could see, it truly has been fully tried and fairly tried and it's all there in the evidence for you to make your judgments. Conversely, I would say to you that if this case were retried and has to be

retried, that is to say mistried because of a hung jury of sorts and we did it all over again, I wouldn't know how to say that the case could be better tried to another jury. I think I made it clear when we closed out seven weeks ago or whenever, this is probably the best tried case by the best kind of attorneys that I have ever had the privilege to officiate with, and you should know that. As to those instructions that you had, ninety-four in number, took me three hours to read them to you, if you recall, again, so far as I can see, taking in account the instructions and the questions that are somewhat self-explanatory, it's the best I can make them. I'm just human and they are as clear as I know how to do. But, more than anything else, if we had to ever face down to that situation and we start over, somewhere down the line, honestly, folks, we can look this world over and we are not going to find a better jury, any of us, than you people that have given so much now of your time and your talent. Indicating you're a congenial bunch and you have kept your wits and your humor, certainly a well-balanced cross-section with good common sense, and all of the lawyers know it and I know it and you know it. All of us are impressed. We are impressed with your attention span, your notes as you kept them. I'm convinced that when ya'll went to that jury room you truly did know about as much as you're ever going you [sic] think you need to know in this field.

Again, it is just a reminder of that. I would encourage you, don't give up, and come to grips with who you are. You're the best kind of jury that this Court could ever ask for, so I would encourage you to stay in there.

If I had any parting thoughts -- and you indicated you want to go home, welcome to -- maybe it is just to draw on some human nature qualities that probably persuade any kind of a body such as a jury that are each asked for your input and your own views and your own thoughts of the matter, you draw from your own good experiences and put your own sense of common sense into the background. Maybe, however, when all that transpires, work at it and think through it and come to grips with the questions, human nature sometimes can be that you wander away from your instructions and put into the factors here things that aren't in evidence and you may be holding judgments that aren't in evidence or considering extraneous matters that you should not be considering. And human nature is that but you should remember that. People just sometimes are set in their ways or hardheaded or obstinate or things of that character, and that is their nature, but that same person with good common sense, knowing his or her duty, should also know that that's not proper here if they can also realize they have some obligation to listen to the other side and try to come to grips and blend your own views with theirs, if you can.

I can think, by example, my own experience with other jurors has been that sometimes as you're picking on a particular decision or rule or evidence or what happened in this event or that, that you are drawing from the criminal experience as opposed to your duties in the civil case. I addressed that, I think, in the jury selection. In jury cases here in hearing a criminal case sometimes as they start -- you have to test the evidence beyond any reasonable doubt and set aside these exigencies, still have a reasonable doubt in their mind, then they have to acquit somebody. I think human nature is that in civil cases sometimes the people test the evidence in a more severe test than they should if they understand the responsibility in a civil case, which is to approach it reasonably. The test really is to test it in the framework of is it more likely so than not that this occurred? Is that a reasonable proposition? Am I persuaded reasonably? I wouldn't know if that is your problem or not. I just know that human nature is sometimes that people pick on something that maybe is not a fair test. If they look at it reasonably, they can see it in a different light if they understand that is your responsibility in a civil case, as I know you do. I closed the other day when I mentioned lastly that probably in jury selection we ought to inquire if people like puzzles, and I think that does have some application. Jurors are really expected, understanding the case, to do their deadlevel best to see if they can make that puzzle fit all together. You talk of forty plus witnesses and three hundred

exhibits and all of the records that you have up there, that's what you're asked to do. You're challenged to see if you can be persuaded reasonably that that puzzle fits. If when you're all done, you find that there is a missing piece of that puzzle, then it doesn't fit. It's that simple. But in this case, the instructions I think tell you what you're charged to do. All the pieces are on the table and it's for you now to put them together as best you can.

So, if I can only leave you with this word as to what I said up front in those instructions, that you surely have to remember you did take an oath in this case and all of us expect you to carry it out, as we know you will. Somewhere in those instructions I certainly say you must remember that you're not partisans in this case. You don't have your favorites. You have to be jurors and fact finders and then charge the case in that light and understand what you have before you and your responsibilities. I know you can do it. I think what you said to me, sir, you think you can do it.

I don't know if what I have said here has helped at all, but I did think it was time to maybe in light of what was said to my clerk, ought to bring you down and just kind of refresh you on some of your responsibilities and urge you on and certainly to inquire if there was any serious problem. I take from what you said, sir, at this moment that there's not. And I would only leave you to say that if time

is a problem, just stay in there. If you need more time, take it. Nobody here would remotely tell you that anyone, is impatient with this jury. We're not. We'll stand by to Halloween if need be awaiting to hear from you.

So, that is about all I can say now. And, again, if you want, you want to go up and commence your deliberations or take a break, want to go home, get a good nights sleep, walk around the chair, whatever you do, do it; then tell us what you want to do. You want to come back in the morning, that is fine. All right. Okay. You're excused. Thank you.

19/ The court addressed the jury at pp. 64-67 of the JQRP as follows:

All right. Let me just make this observation and I have handed a formal statement to you and I do appreciate your communications and your patience and I say that again. I'm going to ask you, however, that you continue with these deliberations in an effort to agree upon a verdict and dispose of this case.

I wanted to make additional comments here that you might consider as well: Again remind you of the importance of this case. If you should fail to reach a decision this case is left open and undecided. Like all cases, it must be decided sometime. No

reason to believe that the case can be tried again in any better or more exhaustive way than it has been. There is no reason to believe that more evidence or clearer evidence would be produced on behalf of either side. Finally, there is no reason to believe that the case would ever be submitted to seven people more intelligent, more impartial or more reasonable than you. Remember that the plaintiffs need only convince you of the sufficiency of their claims by a preponderance of the evidence. That is, more likely so than not. Plaintiffs do not labor under the higher burden of proving their claims beyond a reasonable doubt. If a substantial majority of your members agree on the absence of particular elements of the plaintiffs[']' claims under the preponderance of evidence standard, each dissenting juror ought to reconsider his or here [sic] views since the evidence appears to make no effective impression upon the mind of others. On the other hand, if a majority of you find the plaintiffs have established the elements of their claim by a preponderance of the evidence, the other jurors ought to ask themselves again and most thoughtfully whether they are evaluating the evidence under the correct preponderance standard or whether they should continue to distrust the weight and sufficiency of evidence which convinces their fellow jurors that the elements of the plaintiffs' claims are more likely so than not. The fact each dissenting juror entertains some doubt about plaintiffs' claim does not necessarily mean that the plaintiffs have failed to

produce a preponderance of the evidence to support their claim. Evidence must be evaluated under the correct standard without bias, prejudice or sympathy towards any party. One great mistake jurors or juries make in deliberating ofttimes ~~on~~ a verdict in a case is injecting an issue into the case which was not brought up or contended for in the courtroom trial or on which there is no evidence whatsoever. One good cure for such a misunderstanding and misconduct of a juror or jurors is to carefully read the instructions of the Court which focus on the issues to be decided. The Court's instructions contain the advice that a juror may use his or her common sense in evaluating facts shown in the evidence. This advice clearly means that if some fact asserted is so contrary to human experience and belief, it may be rejected as not true, or if the fact is in accord with such ordinary human experience and belief, it may[ ]be accepted as true. Most of the jurors' mental function is to use his or her sense of good judgment to determine the truth, which means determining the believability of evidence admitted by the Court. Use of common sense does not include or invite the consideration or introduction of discussions by a juror of a fact, situation or issue that's not in this case. Likewise, the permission to use one's common sense does not mean a juror is licensed to decide the case any way they wish. The verdict must be based on the belief or disbelief of part or all of the evidence that is before you. Let me recite again that at all times no juror is expected

to yield a conscientious conviction that he or she may have as to the weight or the effect of the evidence, but you must remember that after full deliberation and consideration of the evidence in the case, it is your sworn duty to agree upon a verdict if you can do so. So, again, you may be as leisurely in your deliberations as the occasion may required [sic] and you should take all the time you feel that is necessary.

Having said that, I will then again ask you that you retire once again to the jury room, and please continue your deliberations with these additional comments in mind to be applied of course in conjunction with all of the instructions that I have previously given you.

I don't know if that will help or not but I would ask that each juror take it to heart, read it and reread it if necessary, as you come to grips with the decision in this case, if you can do it. I will send you back. Thank you very much.

20/ Over three and a half months after the verdict was returned, and *10 minutes* before hearing oral argument on the post-trial motions in this case, I was visited by Mrs. Zelma Greenwood, one of the seven jurors, who delivered a 4-page, handwritten letter to me. In her letter, Mrs. Greenwood recanted her verdict, listing a number of "reasons" she was "forced

into the decision that was given." (Dkt. 281-82.) Her reasons may be of interest to some, but not me.

Mrs. Greenwood proceeded into the courtroom and delivered a copy of her letter to defense counsel Shulman. She offered to provide a copy to plaintiffs' counsel but did not bring one with her into the courtroom. (*See* Dkt. 290, Att'd Aff. of Robert H. Rawson, Jr., ¶¶3-4.) Mrs. Greenwood remained in the courtroom for most of the hearing, as if to be available for the court's inquiry. I announced to all counsel at the outset of the hearing I had just received a troubling communication from one of the jurors and would consider its significance, if any, upon completion of oral arguments. (Dkt. 287, Tran. of Motions Proceeding Jan. 16, 1987, p. 4.) Mrs. Greenwood's letter parrots defendant's present arguments concerning my supplemental instructions to the jury. During the course of oral argument on these points, defense counsel Shulman rather impatiently inquired as to when we would address the matter of her letter. (*Id.*, pp. 83-84.) He later denied knowing she was coming to the hearing, stating that so far as he was concerned it was simply a "coincidence". (*Id.*, p. 145.) In light of my own questions about the import of her letter, I shared copies of it with all counsel and asked them to respond as to its effect, if any. (*Id.*, p. 148.)

I occasionally permit lawyers to communicate with jurors, in certain cases, following return of the verdict and the polling of the jurors. In my view, lawyers and litigants welcome the occasion to extend their appreciation to the jurors for their time and service. But in such an event, and in this case, I first remind the lawyers *not* to discuss the merits of the case, the reasons underlying any of the jury's decisions, or any part of its deliberations.

When the verdict was announced to a full courtroom on September 30, 1986, and after the jurors were polled and released from service, they were so greeted by the attorneys. Indeed, I myself participated in this, stepping down from the bench to host a "receiving line" of sorts. Each juror passed through this line on the way out of the courtroom. I recall my own salutation to Mrs. Greenwood; she exhibited no anxiety about her decision. She, like the others, seemed relieved and even pleased with her role.

Later that evening, as I left my chambers after business hours, I observed defense counsel Shulman and Alioto sitting with Mrs. Greenwood in a hallway adjacent to the courtroom. Surprised, I reminded counsel they were not to discuss the case with her. One responded, "Oh, we're not!" (See also Aff. of Robert H. Rawson, Jr., ¶2.)

Recalling these events, and in light of the "coincidental" appearance of Mrs. Greenwood at the hearing on January 16, 1987, my misgivings heightened. On January 20, 1987, I conferred with United States Attorney Benjamin Burgess and requested that he contact juror Greenwood for the limited purposes of determining if anyone encouraged her letter, suggested its content, or apprised her of the January 16 hearing.

On January 22, Mr. Burgess, accompanied by an FBI agent, met Mrs. Greenwood for the purposes directed. Mr. Burgess then reported to me that defense counsel Shulman and Alioto had returned to Wichita, from Topeka, the day following the verdict and met with Mrs. Greenwood at a Grandy's Restaurant located on South Seneca Street. Following that meeting, Mrs. Greenwood called Mr. Shulman's office on at least one occasion to inquire whether he received the "'first draft'" of her letter. Approximately one week before oral argument on the post-trial motions, counselor Shulman telephoned Mrs. Greenwood and informed her that hearing was scheduled for January 16, at 1:00 p.m.

The state courts of Minnesota, where counselor Shulman is licensed to practice, have made it abundantly clear attorneys should refrain from contacting jurors in hopes of impeaching a verdict. *See Olberg. v. Minneapolis Gas Co.*, 291 Minn. 334, 191 N.W.2d 418 (1971). Why defense counsel might

hope the rule is any different in this court, particularly in light of my two-fold warnings not to discuss the merits or the deliberations, is beyond belief. Further, it is axiomatic that where, as here, a jury gives its unanimous assent to a verdict, individual jurors will not thereafter be permitted to impeach their verdict. *See* Fed.R.Civ.P. 606(b); *United States v. Miller*, 806 F.2d 223 (10th Cir. 1986); *United States v. Vanelli*, 595 F.2d 402, 407 (8th Cir. 1979); *United States v. Schroeder*, 433 F.2d 846, 851 (8th Cir. 1970), *cert. denied* 401 U.S. 943 (1971); *United States v. Chereton*, 309 F.2d 197, 200 (6th Cir. 1962), *cert. denied* 372 U.S. 963 (1963); and *United States v. 16,000 Acres of Land, etc.*, 49 F.Supp. 645, 654 (D. Kan. 1942).

This inquiry need proceed no further. Defense counsel knowingly and blatantly violated my express rulings to avoid any communications with the jurors regarding the case or their deliberations. Adding insult to injury, Mr. Shulman, an officer of this court, misrepresented on the record his involvement. This entire matter reeks of fabrication and contrivance, if not obstruction of justice. *See generally* 18 U.S.C. §1503 (influencing a juror), and §1509 (obstruction of court orders). Defendant's motion for an evidentiary hearing is overruled; I refuse to lend any credence whatsoever to so-called "evidence" obtained in this contemptible manner.

APPENDIX D

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF KANSAS

No. 85-6027-K

WALTER L. REAZIN, M.D.; HCA HEALTH SERVICES OF KANSAS, INC., d/b/a Wesley Medical Center; HEALTH CARE PLUS, INC.; and NEW CENTURY LIFE INSURANCE CO.,

Plaintiffs and
Counterclaim Defendants,

VS.

BLUE CROSS and BLUE SHIELD OF KANSAS, INC.,

Defendant and
Counterclaim Plaintiff,

and

HMO KANSAS, INC.,

Additional
Counterclaim Plaintiff,

VS.

HOSPITAL CORPORATION OF AMERICA,

Additional
Counterclaim Defendant.

MEMORANDUM AND ORDER

The parties to this action are Hospital Corporation of America (HCA) through its subsidiary, HCA Health Services of Kansas, Inc., doing business as Wesley Medical Center (Wesley); Health Care Plus, Inc. (HCP), and New Century Life Insurance Co. (New Century), both HCA subsidiaries; Walter L. Reazin, M.D. (Reazin); and Blue Cross and Blue Shield of Kansas (BCBSK). Plaintiffs contend BCBSK's threatened termination of its contracting provider agreement with Wesley, if carried out, will violate federal antitrust, state, and common laws. Defendant answered denying those allegations, and counterclaimed alleging an illegal boycott of its subsidiary HMO Kansas, Inc. (HMOK), and restraint of trade by HCA's acquisition of Wesley, HCP and New Century. Defendant requested, and was granted, permission to add HMOK as a counterclaim plaintiff, and HCA as a counterclaim defendant. (Memorandum and order, Jan. 8, 1986, Rec. 24.) BCBSK then moved for summary judgment on the entirety of plaintiffs' complaint. (Rec. 50-51.) Oral argument on the motion was heard May 9, 1986. Upon full review of the parties' briefs, deposition testimony, evidence and arguments, the Court grants defendant's motion in part and denies it in part, as more fully explained below.

FACTS

In accordance with the dictates of Fed.R.Civ.P. 56(d) the Court finds the following to be the material facts of the case existing without substantial controversy. The parties stipulated this Court has jurisdiction over the parties and venue is properly laid in this district. (Pretrial Conf. Order, p. 4, Rec. 76; hereafter "Stipulation ___ ".)

The Parties

BCBSK is a Kansas corporation organized and doing business in Kansas, with principal executive offices in Topeka, Kansas. Chartered under a special state enabling act, BCBSK is engaged in the business of providing private health care financing to businesses and individuals in Kansas, including businesses and individuals in Wichita and Sedgwick County. It also operates a health maintenance organization in Kansas through HMO Kansas, Inc. (HMOK), a wholly-owned Blue Cross subsidiary. (Stipulation h.) BCBSK's service area includes the entire State of Kansas, with the exception of Johnson and Wyandotte Counties which are serviced by BCBS of Kansas City, a separate organization. (Stipulation j; Johnston Depo., p. 34.) BCBSK and its subsidiary, HMOK, compete with plaintiff HCP in the private health care finance markets in the State of Kansas

and Sedgwick County. (Stipulation k.)

Blue Cross of Kansas, Inc. was formed in 1941 pursuant to special enabling legislation passed by the Kansas Legislature, and was organized as a private mutual nonprofit hospital service corporation pursuant to K.S.A. 40-1801 *et seq.* The primary purpose of Blue Cross of Kansas, Inc. was to provide private health care financing to its subscribers covering health care costs. (Stipulation 1.) In 1983 BCBSK was formed by combining Blue Cross of Kansas, Inc. and Blue Shield of Kansas, Inc., pursuant to enabling legislation. (Stipulation m.)

Under that enabling legislation BCBSK is required to pursue health care cost containment as the primary goal in conducting its business. (Stipulation o.) In the past Blue Cross utilized retrospective reimbursement contracts with Kansas hospitals, providing direct reimbursement on the basis of 104% of allowable costs. (Stipulation p.) Under this "charge reimbursement program," Blue Cross held the right to approve hospital budgets and rate structures, and agreed to pay unlimited charges based on approved rate structures. This program resulted in wide differences in payments to hospitals even in the same geographic area for equivalent diagnoses. (Chase Depo., p. 33.) In the late 1970's, Blue Cross developed a new prospective rate contract for hospitals and encouraged all hospitals in the state to continue as participating providers under the contract. (Stipulation p.)

On January 1, 1984, BCBSK offered a new

contract known as the "Contracting Provider Agreement (Hospital) of the Competitive Allowance Program (CAP)", and again encouraged all hospitals to participate. (Stipulation p.) The CAP program established the maximum amount BCBSK would reimburse a provider for services within a particular diagnostic related group (DRG). In cases where a patient remains in a hospital and generates more charges than the established allowable, BCBSK nevertheless reimburses the hospital only up to the CAP amount. (Chase Depo., p. 33.) CAP is designed to guarantee BCBSK receives competitively favorable reimbursement levels from participating hospitals, thereby insuring BCBSK can continue to offer a competitively priced product to the subscribing public. (Johnston Depo., p. 180.) CAP also acts to control health care costs by providing hospitals incentives for cost effective management. (Chase Depo., p. 33.)

Under the contracting provider agreements hospitals provide services to BCBSK subscribers, which services are covered by the subscribers' BCBSK insurance policies. The contracting provider agreements contain a number of cost containment provisions, perhaps the most important of which requires the hospital to accept the "maximum allowable payments" (MAPs), established by BCBSK for various services, as payment in full for those services provided BCBSK subscribers. This "hold-harmless" provision ensures subscribers will not receive bills for covered services in excess of the

amount BCBSK pays a participating hospital; it protects subscribers by assuring predictability of their health care expenses. (Stipulation o.)

The MAP program is not a guarantor of ultimate cost containment, but an initiative by BCBSK to inhibit premium rate increases for its subscribers. (Johnston Depo., p. 176.) BCBSK establishes MAPs within various "peer groups" within the State of Kansas. Peer Group V, including the four Wichita hospitals, is one of two geographically determined peer groups in the state; Topeka hospitals constitute the second geographically determined peer group. Peer groups for the remaining Kansas hospitals are established on a statewide basis by reference to hospital size. (Stipulation t.)

Another important provision of the contracting provider agreements is the "most favored nations" clause, stating that if a hospital decides it can provide services at charges less expensive than the MAPs, BCBSK subscribers will have the benefit of the less expensive charges. (Johnston Depo., p. 181.) The clause states:

> In the event that the hospital has entered into an agreement with any other party under which such hospital agrees to accept an amount for any or all services as payment in full which is less than the amount such a hospital accepts from BCBS as payment in full for such services, such lesser amounts shall be the maximum allowable payment

> hereunder. Further, if the hospital provides discounts for cash or for other payment arrangements on a routine basis, such discounted amounts shall be the MAP hereunder if that amount is less than the MAP. The hospital agrees to fully and promptly inform BCBS of the existence of such agreements or discounts and their effect on the amounts which are accepted as payment in full. This paragraph shall not be construed as applying to reimbursement arrangements between the hospital and a BCBS owned or operated HMO operating under a certificate of authority issued by the State of Kansas, or reimbursement under Titles XVIII, XIX and V of the Social Security Act.

(*Id.*, p. 185; Depo. Exh. 14, p. 4.) This clause requires a contracting hospital to give BCBSK the most economical rate the provider can charge, whether or not that rate is given to competing third party payors. BCBSK does not want other insurance companies receiving lower rates from its contracting hospitals. (*Id.*, p. 182.) Contracts of other insurance carriers contain similar clauses. (*Id.*, p. 184.)

Under the BCBSK enabling act, hospitals are not required to contract with BCBSK but in their own discretion are permitted to choose either contracting status ("participating hospitals"), or noncontracting

status ("nonparticipating hospitals"). (Stipulation n.) BCBSK's historic policy has been to enter contractual arrangements with as many Kansas hospitals as possible in an effort to contain costs (Haas Depo., p. 45), and to encourage hospitals to remain on participating status (Johnston Depo., p. 168). The benefits to a participating hospital are significant: periodic interim payments from BCBSK; on-line electronic verification of patient benefits; predictability of, and prompt direct payment of benefits; a corresponding good cash flow and reduced or eliminated potential for bad debts; tape-to-tape billing programs; listing in the BCBSK directory of providers; a better and valuable public image of providing high quality care at reasonable cost; representation on the BCBSK Board of Directors; and access to newsletters, manuals and training. (Stipulation n; Johnston Depo., pp. 73, 162-65; Chase Depo., p. 34.) BCBSK obviously benefits from hospitals remaining in participating status, guaranteeing the best possible price for services provided to its subscribers, and assuring its subscribers will not be exposed to excess charges beyond those prices. (Stipulation o; *passim*.)

In general, the disadvantages associated with noncontracting status cut broadly and deeply, injuring everyone concerned. It is unsatisfactory to merely state the hospitals simply lose the benefits they are otherwise entitled to. The loss of periodic interim payments and direct payment of benefits from BCBSK has a tremendous impact on the cash flow of

a noncontracting hospital. Eliminating the tape-to-tape billing program requires the hospital to submit its claims on paper, a more costly and time consuming process for both the hospital and BCBSK. Part V.f. of the standard BCBSK subscriber agreement provides BCBSK will pay insurance proceeds directly to participating hospitals, but proceeds for medical services performed by noncontracting hospitals will be paid only to the subscriber and may not be assigned. BCBSK does not honor or recognize subscribers' assignment of benefits to noncontracting hospitals. (Stipulation hh, ii.) This is designed to have an adverse impact on the hospitals' accounts receivable and bad debts, an incentive to encourage hospitals' participation. Indeed, BCBSK's entire program is designed to make it to the subscriber's disadvantage "to maintain a contractual relationship with an institutional provider that is noncooperative in future Plan activities." (Johnston Depo., p. 82, Depo. Exh. 3.) The subscribers lose the guarantee of coverage and are exposed to personal financial liability in the event the noncontracting hospital's charge exceeds the BCBSK MAP. (Manley Depo., p. 51.) Nor is BCBSK unscathed. In addition to the increased time and costs associated with processing paper claims from noncontracting hospitals, BCBSK cannot make available to its subscribers the unique hold-harmless provision of its contract; nonparticipation "certainly inhibits the effectiveness of [its] cost containment programs;" and BCBSK may lose subscribers.

(Johnston Depo., pp. 84, 169-70; Chase Depo., p. 35; Haas Depo., p. 48; Manley Depo., pp. 88, 94-96.)

BCBSK is the largest private health care financing organization in the State of Kansas and in Sedgwick County. During 1985 all hospitals and approximately 90% of all physicians in its service area were under contract with BCBSK as providers of medical services to its subscribers. (Stipulation j.) BCBSK's subscriber enrollment is approximately 37% of the total population, both medically insured and that without insurance, in its service area. (Johnston Depo., p. 53; Miller Depo., p. 30.) That figure is down from a total 46% of the Kansas population insured by BCBSK in 1980. (Miller Depo., p. 180.) But BCBSK still accounts for over 61% of the earned health insurance premiums in its service area, while its next largest competitor, Bankers Life Insurance Company, accounts for less than 4.3% of the earned health insurance premiums in the BCBSK service area. (113th Annual Report of the Kansas Dept. of Insurance.) Although there are a number of other insurance companies offering a range of products with competitive benefits, financial alternatives and more, BCBSK is unique in its hold-harmless provision under which a contracting provider must accept BCBSK reimbursement as payment in full. (Johnston Depo., p. 60.) There are few, if any, other insurance programs offering Kansas subscribers the same opportunity of complete freedom of choice in selecting a health care provider that is available under the BCBSK CAP indemnity

insurance program. (Chase Depo., p. 44.)

HCA is a Tennessee corporation with principal executive offices in Nashville, Tennessee. Through its subsidiary corporations HCA is engaged in the businesses of providing health care services, private health care financing and hospital management services throughout the United States. (Stipulation g.) HCA is the largest corporation in the country involved in ownership and management of acute health care facilities. (O'Brien Depo., p. 62.) But it is also a diversified company with a recognized policy of seeking "vertical integration" in the health care industry. HCA has, or is currently pursuing, interests in a nursing home company, a medical supply company, health and medical equipment companies, and insurance and third party insurance administrator companies. (Stewart Depo., p. 98; Kilissanly Depo., p. 100.) In 1985 HCA acquired Wesley, HCP and New Century, which are now wholly-owned subsidiaries of HCA. (Stipulations g, u, v, w.)

Wesley is a Kansas corporation with principal executive offices in Wichita, Kansas. Wesley is located in Wichita and provides health care services to residents of Wichita, Sedgwick County, and the State of Kansas, as well as out-of-state patients. (Stipulation d.) It is a tertiary care hospital with a higher degree of sophistication and specialization in its services than is available at primary or secondary care institutions. (O'Brien Depo., p. 147; Sullivan Depo., p. 15.) Additionally, Wesley is a major

teaching hospital with a strong medical education program. (Sullivan Depo., p. 14.) Wesley is one of four incorporating hospitals which formed "Health Frontiers", a network of some 30 hospitals located in Kansas, Nebraska and Oklahoma, created to undertake affiliated group programs including joint purchasing, sharing of office services and expertise, economies of scale, etc. (O'Brien Depo., p. 80.) Wesley has been under contract with Blue Cross since the 1940's, and was a charter member of the original Blue Cross program formulated under the Kansas enabling statute. The hospital has been a participant in BCBSK's CAP program from its inception in 1984. (Stipulation q.) Wesley is currently a party to a contracting provider agreement with BCBSK, under which Wesley agrees to provide acute care services to BCBSK subscribers and accept the BCBSK maximum allowable payment (MAP) for those services as payment in full. That contracting provider agreement became effective July 1, 1985 and was delivered by BCBSK in the middle of that month. (Stipulation r.)

Health Care Plus is a Kansas corporation established in early 1981, with principal executive offices in Wichita. HCP is a health maintenance organization (HMO), providing private health care financing to businesses and individuals in Kansas, including Wichita and Sedgwick County. (Stipulation e.) Following its acquisition by HCA, HCP began marketing its products in Texas, Louisiana, Arkansas and Missouri, as well as continuing its efforts in

Kansas. (Kilissanly Depo., p. 137.)

New Century is a California corporation with principal executive offices in Nashville, Tennessee. New Century is engaged, *inter alia*, in the business of providing private health care financing to businesses and individuals. (Stipulation f.) New Century was issued a certificate of authority to do business in Kansas June 10, 1983. It is currently seeking regulatory approval to begin selling health care financing products in this state, and although delayed, this approval is expected sometime this year. *Id.* Once state approval is acquired HCP, rather than New Century itself, will be marketing the New Century products. (Kilissanly Depo., p. 41.)

Plaintiff Reazin is a medical doctor and a partner in Hillside Medical Office in Wichita. (Stipulation c.) Dr. Reazin is on the medical staff at Wesley providing medical services to the hospital's patients; during most of the time period relevant to this suit Dr. Reazin was also Chairman of the Board of Trustees of Wesley. (*Id.*; Reazin Depo., pp. 12-13.) He is a BCBSK subscriber by virtue of his partnership in the Hillside Medical Office, which has a subscriber agreement with BCBSK. (Stipulation b.)

The Market

During 1984, there were four Wichita hospitals competing for patients. Wesley, with 798 beds, garnered approximately 43% of all Wichita inpatient

admissions; St. Francis Regional Medical Center (St. Francis), with 776 beds, obtained approximately 30% of the admissions; St. Joseph's Medical Center (St. Joseph), with 565 beds, held slightly over 22%; and Riverside Hospital (Riverside), with 125 beds, secured approximately 5% of the total admissions. (Berry Depo., p. 93; BCBSK Exh. 80.) Wesley was by far the strongest of the four Wichita hospitals. (BCBSK Exh. 105, p. 5.)

In this market there were over 200 indemnity insurers doing business with these four hospitals as third party payors. (Sullivan Depo., p. 168.) BCBSK was premier among those insurers, occupying a unique market position because of its statutory mandate under Kansas law to reduce health care costs. (*Id.*)

The economic forces and changes experienced by the health care service and insurance industries throughout the last decade play a significant role in this case. BCBSK Exhibit 156, an "Environmental Trends" report prepared by the HCA Center for Health Studies, provides a good deal of background material necessary to understand what motivated these parties to act, and react, as they did.

The macroeconomic trends affecting all sectors of the economy include three particular characteristics acutely affecting health care service and insurance. Long-term structural changes occurring in our country's economy reflect shifts away from manufacturing, agriculture and raw materials toward a service and information economy; toward continued

reduction or elimination of regulations originally established to protect industries and/or consumers; and toward major restructuring in established industries, resulting in expanded, intensive competition. A "bimodal" population is developing, concentrating numbers in the elderly and the maturing "baby boomers" groups, with corresponding changes in consumer sophistication, income levels, and spending priorities. Finally, there is rapid change in information and biological technology, impacting health care through increased productivity, more effective diagnostics and treatment, and increased competition for capital. (BCBSK Ex. 156, summary and pp. 1-7.)

The effect of these and other changes on the health industry have been, and continue to be, severe. The inpatient market has experienced a dramatic decline. Nationally, total hospital inpatient admissions dropped 7.3% from the first quarter of 1983 through the third quarter of 1984. Even within the group of patients continuing to seek hospital inpatient services, the lengths of stay have decreased significantly. Between 1983 and 1984, lengths of stay dropped 5.3% for the under 65 population and 10.8% for the 65 and over population. The existing market forces of increased competition, new payment systems, health care cost concerns, new delivery systems and technologies, and consumer preferences are acting to cause further reductions in discretionary inpatient utilization. (BCBSK Exh. 156, pp. 8-11.)

The federal and state governments are seeking to

restrict their roles as purchasers of health care services because of the continued high cost. In 1983, the federal government switched from the "cost plus" system of Medicare and Medicaid reimbursement to a market-driven system with a schedule of fixed payments to providers for diagnostic related groups (DRGs). The new system has prompted physicians to rethink their practice patterns for all patients and encouraged hospitals to better manage utilization. In 1984 BCBSK followed the government's example and implemented the CAP program with fixed DRG payments in Kansas. Both federal and state governments are considering regulatory solutions to the problems of health care cost and indigent care. Some states have placed moratoriums on new hospital beds; others are restricting hospital acquisitions by investor-owned companies; and still others are considering rate setting systems designed to both control costs and resolve the indigent care issue. The need to control quality of care becomes more important and difficult given the continued decline in inpatient volume and growing pressures to cut costs. (BCBSK Exh. 156, pp. 17-19.)

Within the health care service sector, there are emerging a number of alternatives to the traditional inpatient setting. Outpatient surgery centers are expected to grow in number by 177% from 1984 to 1988. The cost savings for services obtained at these outpatient centers, as opposed to inpatient services, is substantial, ranging from 38% to 59% for particular services. Up to 60% of all surgical

procedures can now be performed on an outpatient basis. Freestanding minor emergency centers (often called "urgent care centers") continue to grow in number, as do birthing centers in which it is projected 30-40% of all births will occur by 1990. Technological developments, patient acceptance, financial incentives and investor interest all encourage the growth of these and other alternative services and settings. These outpatient alternatives place hospitals' inpatient business at risk, and drive the hospitals themselves to expand and offer an increasing number of market-driven outpatient delivery alternatives. (BCBSK Exh. 156, pp. 20-22.)

The distinction between health care providers and insurers is blurring with the rapid development of "brokered" arrangements for the purchase and provision of health services. These brokered arrangements may be sponsored by hospitals, physicians, insurers, or a combination of the three, and may be negotiated through a number of different vehicles including health maintenance organizations (HMOs), preferred provider organizations (PPOs), or other direct contract agreements. Whatever their form, these brokered arrangements share three common elements: the sale of health benefits in a wholesale market to group purchasers attempting to obtain health services for less than full retail price; a contractual arrangement between providers and purchasers more narrowly restricting consumer choice to a select provider panel; and management systems designed to insure cost effective utilization of health

services. Brokered arrangements are fueled both by demand, from businesses and governments as major purchasers of health services seeking to control and/or reduce their health expenses while assuring beneficiaries receive quality services, and by supply, from health care providers seeking to protect and/or increase their market share of patients in light of decreasing inpatient utilization and increasing competition. The growth in HMO membership is expected to exceed 300% by 1990. The Medicare and Medicaid programs have consistently encouraged the growth of HMOs. Nearly two-thirds of the companies surveyed in a 1984 study had incorporated HMOs into their medical plans as a cost control option. PPOs continue to grow at a significant rate. The plans which will succeed as brokered arrangements are those which can: offer, either themselves or through contract affiliations, a full range of health services; control the costs of their benefit packages; maintain quality of care; and aggressively market their product. (BCBSK Exh. 156, pp. 12-14.)

The merger of health services and insurance goes beyond the development of brokered arrangements. As a result of a growing market for integrated health care delivery and financing systems, the health care product is being "repackaged" with hospitals and hospital companies integrating into health insurance functions, while insurance companies are developing networks of health care providers. Market forces influencing this consolidation and integration include:

fixed price and capitation payment programs from government, business and insurance companies; payors assuming the role of purchasers, seeking a package of health services and financing; consumer awareness of, and increased responsibility for, ever increasing portions of their health care bills resulting from increasing co-payments and deductibles; and competition and excess capacity leading to provider and insurance company initiatives to improve market position. (BCBSK Exh. 156, pp. 15-16.)

All of these trends, and their impact, were felt in Kansas. For example, during the last four years the number of inpatient admissions and lengths of stay in Kansas have dropped precipitously, leaving a growing number of empty hospital beds. It is an insidious cycle, requiring providers to allocate costs over fewer patients, raising patients' costs and regenerating the downward pressures. (O'Brien Depo., p. 161.) Recognizing this emerging, intensely competitive market, BCBSK acknowledged there is a potential for closing or modification in use of some hospitals. (Johnston Depo., p. 129, Dep. Exh. 6.)

Under conventional indemnity insurance arrangements, hospital and other contracting providers are reimbursed by the carrier for services rendered its subscribers on an "as needed" basis. There is no incentive to economize, using the most cost effective methods of practicing medicine, and conventional indemnity arrangements are perceived as giving rise to overuse of medical services. (Johnston Depo., p. 41.) This, combined with other

trends in the health industry, resulted in the emergence of health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Both are prospective reimbursement arrangements based on predetermined monthly payments to providers to oversee all health care needs of a member individual or family. HMOs require their members to choose one primary provider from a select group, and secure all needed services from the provider chosen. PPOs allow their members to secure health services from any of their contracting providers, but that group is also select and does not include all available providers in a given area. Health Care Plus (HCP) was first to enter the Kansas and Sedgwick County markets with its HMO. BCBSK attempted to follow with HMO Kansas (HMOK); it failed in Sedgwick County, and BCBSK then introduced Choice Care, a PPO.

HCP received federal qualification as an HMO in early 1981. With its license it also received the power to require employers to offer their employees an HMO option for health insurance. This mandate power did not mean the employers had to offer only HCP; the employers were simply required to offer employees *one* HMO from those in the market. However, HCP was the largest, if not the only, HMO then available. It used the federal mandate capability extensively, and successfully. By the end of 1984 HCP acquired 40,000 members in Wichita, representing 95% of its total business. (Kilissanly Depo., pp. 117-18.)

HCP's policy is to enter contracts with as many physicians as possible as primary care providers. Each physician is paid a capitation fee, a stated amount for each member choosing that physician as his or her primary provider. HCP does not enter separate contracts with specialists; rather, each primary care physician determines in his own discretion whether to refer an HCP patient elsewhere, after which HCP will pay the specialist's fees. A portion of the capitation fund, the "withhold", and a hospital fund are set aside by HCP to cover specialist and hospital costs for services rendered HCP patients. Those funds not used at the end of a year are returned to the contracting physicians, each of which receives a prorata share of the refund based on the number of HCP patients treated. (Alexander Depo., pp. 17-18.) Two of the most important physician groups contracting with HCP are the Wichita Clinic and Hillside Medical Office.

Although not contracting with specialists, HCP does contract with hospitals. HCP has capitation agreements with Wesley and St. Francis in Wichita. (Kilissanly Depo., p. 49.) Under these agreements the hospitals are paid a certain monthly figure per member. Those amounts are paid whether or not the members receive care at the hospitals, but if the members do seek services there the hospitals must provide care and are paid no more than the monthly capitation. (*Id.*, p. 50.) Wesley is paid an 80% capitation by HCP, that is, $11 per member for 80%

of HCP's membership. (Berry Depo., pp. 124-27; Davis Depo., p. 85.) HCP has fee-for-service contracts with St. Joseph and Riverside hospitals in Wichita, under which those hospitals are not paid capitation but are simply reimbursed for any services which may be provided HCP members. (Kilissanly Depo., p. 50.)

At the end of 1983, HCP implemented a plan to become a for profit corporation. HCP faced financing difficulties at the time. Federal loan guarantees for HMO expansion were being reduced while HCP was attempting to expand from Wichita into other Kansas communities. To acquire the capital necessary for expansion, HCP became for profit and sold stock to investors. (Kilissanly Depo., p. 19.) HCP employees were offered stock at $.25 per share, and physicians who were contracting providers with HCP were offered stock at $1.00 per share, although it was not a condition they purchase stock to retain contracting status. (*Id.*, pp. 58-67.) At this point there was no discussion of going public with the company or seeking acquisition by others. (*Id.*, p. 19.)

Almost three years after HCP was established in the market, BCBSK implemented HMO, Kansas statewide in early 1984. (Knack Depo., p. 106.) In Sedgwick County and Wichita, HMOK encountered difficulty. Wayne Johnston, President of BCBSK, acknowledges HCP's lead time and federal mandate capabilities gave it a particular advantage in the market. (Johnston Depo., p. 57.) Both HCP and

HMOK were "independent provider arrangement" model HMOs; HMOK did not develop a staff or group model which would have been different than HCP. Those employers mandated by HCP could not be mandated by HMOK because it was the same HMO model. Rather, it was simply within an employer's discretion to substitute HMOK for HCP as the required HMO option. (Carmichael Depo., pp. 84-86.) Many did not. HMOK was a "carbon copy" of the HCP program, and many employers saw no reason to offer identical programs. (Kilissanly Depo., pp. 76-77.)

Further, the HMOK provider capitation rates were not significantly different than those of HCP. (Miller Depo., p. 56.) HMOK did offer physicians both limited and full capitation models. The limited model capitated only basic primary care services and paid for additional professional services on a fee-for-service basis. This limited model obviously meant lower risk for contracting providers. But HMOK's statewide policy was that a physician desiring to participate as a provider was required to accept from HMOK the same level of risk the physician had accepted in any contracts with other existing HMOs. Thus, physicians already participating in the HCP higher risk capitation model, similar to HMOK's full capitation model, were not offered HMOK's limited capitation model as an option. If they wished to participate in HMOK they were required to accept the full capitation model with corresponding higher risk. (Knack Depo., pp. 20-31.)

By July, 1984 HMOK had approximately 1800 members, and contracts with slightly over 100 primary care physicians in Wichita. (Knack Depo., pp. 115-16.) HMOK's contracts with the Wichita Clinic and Hillside Medical Office were terminated by those groups in August, 1984. BCBSK claims it was never given any reasons for those cancellations, but earlier there had been considerable concerns raised about the levels of HMOK capitation and reimbursement provisions, the lack of patient load, and corresponding risk to the physicians. (Knack Depo., pp. 120-23; O'Brien Depo., p. 172; Reazin Depo., pp. 18-19; Kilissanly Depo., pp. 73-76.) Following the groups' cancellations, there was a significant drop in the remaining number of physicians participating with HMOK. (Knack Depo., p. 117.) BCBSK withdrew HMOK from the Wichita market in late 1984, although the program remained in effect elsewhere in Kansas. (*Id.*, p. 115.)

The Sales

In 1984 Wesley was by far the largest, strongest and most competitive low cost, not for profit tertiary care hospital in the area. Concerned more about Wesley's future than its current market position, in the fall of 1984 the hospital's administrators began a feasibility study of the sale of its assets to a well-financed, investor-owned for profit corporation. The factors which motivated this decision included many of the market trends and economic forces previously

discussed. In Kansas there had been more than a 50% drop in the utilization rate of inpatient days per 1000. (O'Brien Depo., p. 153.) In addition to the reduced utilization rate, Wesley was faced with increasing regulatory controls and restricted revenue from third party payors; increasing competitive forces; and increasing capital requirements. Sale of the hospital's assets to a profit corporation was perceived as offering the following advantages unavailable under any of the other options considered: unlimited access to capital; system efficiencies (purchasing, marketing, accounting, regulation, etc.); reduced economic risk; improved market position; preservation of quality; and an expanded, enhanced health care mission. (Stewart Depo., pp. 104-05; BCBSK Exh. 31.) Although a number of profit corporations were initially considered as potential purchasers, the choice was quickly narrowed to HCA, "a clear leader in the field," and negotiations continued throughout the fall of 1984. (Reazin Depo., p. 78.) In November, 1984 the parties agreed to the sale of Wesley's assets for approximately $265 million, an "extraordinary" price. (*Id.*, p. 79.) Of that amount, approximately $65 million was used to retire debts, bonds and assumed obligations; the remaining $200 million went to Wesley Foundation, out of which a $30 million endowment will be paid to the United Methodist Church, the former owner of Wesley. (Stewart Depo., p. 105.) HCA committed itself to local board control of the hospital, and Wesley has the right to

repurchase the hospital at the end of five years if dissatisfied with its operation by HCA. (*Id.*, p. 107.) On July 11, 1985 HCA, through its wholly-owned subsidiary HCA Health Services of Kansas, Inc., acquired Wesley. (Stipulation v.) Wesley's for profit status required it to withdraw as a member of the Health Frontiers network of hospitals. Health Frontiers was dissolved and reorganized following the sale, and HCA/Wesley now has affiliation contracts with some of those hospitals. (Reazin Depo., p. 73; O'Brien Depo., pp. 81-83.) HCA is not currently negotiating for the purchase of any other Kansas hospitals, but it does have management contracts with hospitals in Coffeyville, Fredonia, and Emporia, Kansas. (O'Brien Depo., p. 84.)

Contemporaneous with HCA's purchase of Wesley, but prior to entering negotiations for the purchase of HCP, HCA acquired New Century on April 25, 1985. (Stipulation u.; Kilissanly Depo., p. 98.) At the time of its sale New Century was licensed to operate in over 20 states, including Kansas. HCA's plan was to develop a full line of preferred provider and health insurance products and market them throughout the country in competition with other indemnity insurers, including BCBSK. (Reeves Depo., pp. 16-23.) New Century is currently awaiting regulatory approval to sell its products in Kansas. (*Supra*, p. 11).

In early 1985, HCP began looking at the possibility of a sale to, or affiliation with, a large company to secure financing needed for national

expansion. (Kilissanly Depo., pp. 90, 96.) St. Francis and Wesley were considered and approached, but they declined interest in the face of HCP's extensive financial needs. A. B. Davis, Chairman and Chief Executive Officer of Wesley, told HCP that HCA might be interested. (*Id.*, p. 112.) Negotiations between HCA and HCP resulted in the sale of HCP for $41.1 million. (*Id.*, pp. 125-26.) Through its subsidiary Health Care Plus of America, Inc., HCA acquired HCP on August 14, 1985. (Stipulation w.) The purchase price was the equivalent of $18.00 per share of outstanding HCP stock. The employees who purchased stock at $.25 per share, and the participating physicians who purchased stock at $1.00 per share, made substantial profits from the sale. HCA assumed HCP's existing negotiations for acquisition of a third party health insurance claims administrator, which was completed by HCA in late 1985. (BCBSK Exh. 347.) HCP will be responsible for marketing New Century health insurance products in Kansas following regulatory approval. (Smith Depo., pp. 59-62.)

BCBSK repeatedly emphasizes HCA's goal of vertical integration in the health industry, and the effect of that goal on Wesley, HCP, New Century, BCBSK, and the Sedgwick County market. Both Wesley and HCP were aware of the vertical integration policy at the times of their acquisitions by HCA. Following these acquisitions HCA informed Wesley and HCP that HCA had channeling mechanisms to direct patients to HCA hospitals

where feasible. (Bugg Depo., pp. 153-56; Kilissanly Depo., pp. 151-54.) But HCA had also assured HCP during negotiations that HCA would not attempt to force HCP to change the way it does business. HCP has always sought, and continues to seek, an insurance product with a broad provider base to maintain appeal to the subscribing public. (Kilissanly Depo., pp. 102-03.) Although there are HCA corporate objectives for its insurance services to identify and coordinate development with hospitals owned or managed by HCA, HCP personnel have found these hospitals unwilling to give discounts of any significance. (*Id.*, pp. 185-89.) HCP continues to contract with Wesley and the other three Wichita hospitals not owned or managed by HCA. Although Wesley does meet with HCP on a monthly basis to coordinate marketing and other efforts, Wesley has implemented its own PPO called "Care Plus Network", which competes with both BCBSK and HCP. Regarding the relationship between Wesley and HCP, HCA told Wesley personnel to "continue doing business as the Board of Trustees and management staff see fit." (O'Brien Depo., pp. 29-34.) From the time of Wesley's acquisition by HCA through the time of BCBSK's announced termination of Wesley as a contracting provider, there was no change in the manner in which Wesley interacted with BCBSK regarding that contract, and throughout Wesley remained one of the lowest cost providers in Wichita. (Johnston Depo., p. 203.)

The Response

After abandoning HMOK in Wichita in late 1984, BCBSK attempted to re-enter the market the following spring with a preferred provider organization known as "Choice Care". Bids were solicited, and Wesley and St. Francis hospitals, bidding discounts in excess of 20% of their regular rates, were chosen as the successful bidders. (Knack Depo., pp. 81, 87-88.) But before BCBSK executed final agreements with these providers, it made modifications to Choice Care which changed the assumptions on which Wesley based its bid. Wesley anticipated only a small Choice Care physician provider base, approximately 35%, with stringent utilization controls to be exercised by BCBSK. After Wesley's and St. Francis' bids were accepted, BCBSK broadened the physician participation base and eliminated the physician at risk withhold, shifting responsibility for utilization control to the hospitals. (O'Brien Depo., p. 106.) Although the modified Choice Care program would have appealed to more physicians and subscribers, it exposed the hospitals to a higher financial risk for the same reasons. The hospitals' bids were calculated on assumptions of a certain patient load, and BCBSK's subsequent modifications meant the lower rates would be given to more patients than the hospitals anticipated. Choice Care provides no coverage to subscribers choosing a noncontracting hospital for nonemergency reasons. (Johnston Depo., p. 195.)

During the spring of 1985, BCBSK also attempted to reestablish a "new" HMOK in Wichita. The HMO under consideration was designed to limit the number of participating hospitals and physicians in a manner different from the HCP arrangement. (Dauner Depo., p. 129.) St. Joseph was first contacted by BCBSK about this program in early April, 1985 (Sullivan Depo., p. 69), and shortly thereafter St. Francis was included in their discussions. In the first meeting with St. Joseph, BCBSK's Vice President of Marketing, John Knack, indicated the original HMOK had been withdrawn because it entered the market after HCP was well established, and because HMOK's product was almost identical to that of HCP; there was no product differentiation. (*Id.*, p. 70.)

Wesley's annual contracting provider agreement with BCBSK became effective July 1, 1985, and that contract was delivered to the hospital in the middle of the month. (Stipulation r.) The BCBSK Steering Committee met on July 15 to consider a 4% *increase* in hospital MAPs for 1986. (Johnston Depo., p. 207; Depo. Exh. 24.)

On July 24 John Knack, and Marlon Dauner, BCBSK Senior Vice President for External Affairs, met with Edmond Berry, Wesley's Senior Vice President and Chief Finance Officer, to discuss the Choice Care program. The BCBSK representatives attempted to respond to Wesley's concerns about the program and persuade Berry to act on the contract. Berry indicated he was facing problems with the

HCA office in Dallas regarding the contract as written, and asked how Wesley could rebid the program. The BCBSK representatives replied they would not rebid. Berry responded Wesley desired to participate as a Choice Care hospital because "'their intent was to put one of the other hospitals in Wichita out of business, and it was not the small hospital.'" (Knack Depo., p. 95; Dauner Depo., p. 67.) Berry acknowledges there may have been discussion "in a generic sense" about one of the Wichita hospitals going out of business and Wesley working with the other successful bidder in Choice Care, but denies making the statement that was Wesley's intent. (Berry Depo., pp. 46, 180.) Berry concluded the July 24 meeting stating he would not approve the Choice Care arrangement. (Dauner Depo., p. 77.)

Knack and Dauner then proceeded to a scheduled meeting with St. Joseph and St. Francis representatives for further discussions on HMOK. Dauner stated they had just come from a meeting where Berry indicated "'he was going to put one of you out of business.'" (Knack Depo., p. 100.)

Berry's alleged remarks were also communicated to the BCBSK Steering Committee on July 30, 1985. (Knack Depo., pp. 102-03.) At that meeting no decision was made on Choice Care responding to Wesley's concerns, nor was there any mention or discussion of terminating Wesley as a contracting provider under the CAP program. (Knack Depo., p. 103; Johnston Depo., pp. 205, 207.) On that same

day BCBSK sent to Wesley the Choice Care contracting hospital agreement, and contracting hospital policies and procedures, requesting execution of the agreement no later than August 15, 1985 for an effective date of September 1. (Johnston Depo., p. 197; Depo. Exh. 20, 21.)

The termination of Wesley as a contracting provider was first considered by BCBSK in early August, 1985. (Johnston Depo., p. 208.) St. Joseph and St. Francis hospitals indicated they were seeking an equity position in any HMO to be offered, which BCBSK steadfastly rejected. On August 4 the hospitals met with Dauner, Knack, and Bill Pitsenberger, general counsel for BCBSK, to discuss whether those three men would be interested in leaving BCBSK to manage an HMO owned and operated by St. Joseph and St. Francis. Dauner, Knack and Pitsenberger indicated their interest in such a program but required a firm commitment from the hospitals that same day. That commitment was not forthcoming, and the idea was dropped. (Dauner Depo., pp. 23-36; Carmichael Depo., p. 97.) Later that night the three BCBSK representatives developed what is now called "Kansas Health Plan", the new HMO ultimately implemented in cooperation with St. Francis and St. Joseph. (Dauner Depo., pp. 33-34; Knack Depo., pp. 180-81.)

The BCBSK Steering Committee met the following day, August 5. The minutes of that meeting state that "[c]onsiderable discussion occurred concerning the providers in the Wichita area, HMO,

Choice Care, CAP, etc." (Johnston Depo., p. 213; Depo. Exh. 25, p. 2.) Following the formal meeting that morning, Johnston requested the committee to return in the afternoon, when the committee members discussed the general Wichita market and problems BCBSK encountered there. Although not reflected in the official minutes, the members concluded "it would be in the best interest of BCBS for a number of reasons to recommend to our Executive Committee we cease contracting with Wesley and HCA" as of January 1, 1986. (Johnston Depo., p. 214.)

On August 12, 1985, the Steering Committee voted to recommend the Executive Committee terminate Wesley as a participating hospital. David E. Manley, BCBSK Vice President of Subscriber Services, testified at his deposition the rationale for that recommendation was HCA's acquisition of Wesley and HCP and consequent control over both supply and demand, working to the detriment of BCBSK subscribers in Wichita and throughout the State of Kansas; "an assumption" HCA could direct its insured members to particular facilities to seek medical care. (Manley Depo., pp. 48-49.) Johnston testified the recommendation was based on the committee's perception of HCA's intent to pursue vertical integration and "dominate" the Wichita market; the committee's belief Wesley was not genuinely interested in doing business with BCBSK; and Berry's alleged comment regarding HCA's intent to put another Wichita hospital out of business.

(Johnston Depo., pp. 216-20.)

At that same meeting the Steering Committee recognized that as a result of the proposed termination BCBSK would have a significantly different indemnity insurance product in Wichita, offering the CAP arrangement with only three of the four hospitals. Concerned over the marketability of this resulting program, the Steering Committee further decided to seek a reduction in MAPs from the other three Wichita hospitals to acquire a competitive price advantage. (Knack Depo., p. 104; Dauner Depo., p. 82.) The committee also decided to recommend the Executive Committee abandon the Choice Care program in which Wesley was one of the successful bidders. (Knack Depo., p. 182; Dauner Depo., p. 80.) Although not a stated reason for recommending abandonment of Choice Care, Dauner acknowledges Choice Care would have competed with the Kansas Health Plan HMO then under negotiation with St. Francis and St. Joseph. (Dauner Depo., p. 79.)

The next day, August 13, Dauner and Knack attended another meeting with St. Joseph and St. Francis representatives, initially scheduled for further discussions on Kansas Health Plan. Dauner opened the meeting by announcing BCBSK was considering recommending its Executive Committee cancel Wesley's CAP contract. (Knack Depo., p. 183; Carmichael Depo., p. 33; Dauner Depo., p. 147.) Knack and Dauner stated that although they hoped BCBSK could form an HMO with the hospitals,

whether or not that was successful BCBSK needed to protect itself and act to remain competitive faced with its biggest competitor, HCP. (Mackey Depo., p. 47.) BCBSK anticipated the CAP program would continue with St. Joseph, St. Francis and Riverside hospitals, ". . . in effect, a PPO." (Knack Depo., p. 184; Carmichael Depo., p. 34.) Knack and Dauner voiced their concerns over the marketability of the CAP program if the termination were carried out, and asked the hospitals for a 25% reduction in their rates to provide BCBSK a competitive price. (Carmichael Depo., pp. 34-35.) Knack and Dauner also acknowledged that if BCBSK proceeded to terminate Wesley, it could result in short term losses for BCBSK. (Knack Depo., pp. 197-98.) The hospitals were concerned about the proposed reduction in MAPs, and asked about the effect of Wesley's termination on their patient volume. Dauner replied he had no idea. (Dauner Depo., p. 86.)

The following day, August 14, Knack, Dauner, and Pitsenberger attended a meeting of the St. Francis Board of Directors where they discussed the proposed termination of Wesley and the requested reduction of MAPs. (Knack Depo., p. 186.) Knack referred to the possibility, but did not guarantee, that BCBSK subscribers might choose to use a hospital other than Wesley following its termination. (Carmichael Depo., p. 34.) Knack requested a response from St. Francis regarding the reduced MAPs by August 16, 1985; he told the Board he

needed to make a presentation to the BCBSK Executive Committee and felt it would be helpful if he could then indicate St. Francis was willing to accept the lower rate of payment on MAPs. (Carmichael Depo., p. 36; Depo. Exh. 3, p. 7.) The St. Francis Board authorized its administrative staff "to negotiate a contract with Blue Cross after an appropriate discount percentage could be selected." (*Id.*)

BCBSK's contracting provider agreement with Wesley required 120 days notice for termination without cause. BCBSK was accordingly required to give Wesley notice of termination no later than September 1, 1985 for an effective termination date of December 31, 1985.

St. Francis personnel initially requested BCBSK apply the reduced MAPs only to new business and pay the originally proposed 4% increased MAPs for old business. BCBSK rejected that idea. (Carmichael Depo., p. 46.) St. Francis did not affirmatively respond to Knack by August 16 as requested, but in a telephone conversation that week between Knack and Bruce Carmichael, St. Francis' Vice President of Planning and Marketing, Carmichael rejected the proposed 25% discount because it was the hospital's "break even" point, but indicated St. Francis might be comfortable with a 20% discount. (*Id.*, p. 48.)

Representatives of BCBSK, St. Joseph, and St. Francis next met August 21, 1985. (Knack Depo., p. 191.) They discussed discounts for the Kansas

Health Plan HMO, MAPs under the CAP program, and an unspecified PPO. (*Id.*, p. 192.) Knack indicated the proposed Wesley termination had a good chance of being approved. (Sullivan Depo., p. 47.) He also commented on the impact of the proposed termination on the Wichita market, stating he expected Wesley's current 50% share of BCBSK business would be reduced following termination; either directly or indirectly he indicated that if Wesley's BCBSK patient volume was reduced the patients "would certainly go somewhere else in the Wichita area and that it could have a positive impact [with an] increased volume of BCBS patients at the other hospitals." (Sullivan Depo., p. 35.) BCBSK representatives again discussed with the hospitals a 25% rate reduction. (*Id.*, p. 37.)

St. Francis' management staff performed an internal computer cost analysis which showed a 20% MAP discount, with no increase in patient volume, would result in a $1.2 million loss for the hospital. But the same analysis showed that with even a 4% patient shift from Wesley, 2% each benefiting St. Francis and St. Joseph, St. Francis would acquire at least the 300 new patient admissions needed to maintain existing levels of profitability with the proposed reduction in MAPs. (Carmichael Depo., pp. 51-53; Depo. Exh. 4.) This was an acceptable level of risk for St. Francis. (*Id.*)

St. Joseph personnel did not need a computer to account for patient shifts in deciding their course of

action on the proposed reduction of MAPs. That hospital had voluntarily terminated its BCBSK CAP contract for a period of time during 1981, and experienced firsthand the reduction in BCBSK patient volume that accompanies noncontracting status. (Sullivan Depo., p. 45.) St. Joseph was confident the proposed termination of Wesley would reduce the number of BCBSK patients seeking care at Wesley; St. Joseph was amenable to a discount because of the prospect of greater patient volume. (*Id.*) Indeed, the "change in patient volume . . . was the basis for the discount to begin with." (*Id.*, p. 67.)

On August 23, Carmichael from St. Francis, and Edward Sullivan, St. Joseph's Vice President of Administration, met. Sullivan believes Carmichael could have informed him at this time St. Francis had accepted the reduced MAPs. (Sullivan Depo., pp. 59-60.) The hospital representatives also further formulated and discussed the Kansas Health Plan HMO, with the two hospitals as owners and BCBSK handling marketing and claims processing. (Carmichael Depo., pp. 113-14; Mackey Depo., p. 61.)

That same day Wayne Johnston, President of BCBSK, sent a letter to the members of the BCBSK Board of Directors Executive Committee calling a special meeting on August 29: "We have a critical decision to make regarding contracting with hospitals. We found it necessary to call a special meeting of the Executive Committee to consider this critical issue before the scheduled September meeting. . . .

I am enclosing a few articles that I hope will indicate . . . some of the new competitive pressures we feel developing. . . . I think it will become evident that many new competitors are coming on the scene and we will shortly see health care cost price wars." Accompanying the letter were reports and articles detailing the operations and plans of the following health care and health insurance corporations: HCA; American Medical International; National Medical Enterprises; Humana; U.S. Health Care Systems; Prudential; and Cigna. (Johnston Depo., p. 228; Depo. Exh. 28.)

At the August 29 Executive Committee meeting Johnston made a presentation describing BCBSK's present and future positions, general trends in the health care industry and specific trends perceived in the Wichita market. He expressed concerns about price wars, vertically integrated competitors, quality of care and potential closings of hospitals for economic reasons. (Johnston Depo., pp. 229-236.) The question Johnston requested the committee to act on was:

> Does Blue Cross and Blue Shield of Kansas wish to continue to do business,with entities that openly desire to compete with the organization and enroll Blue Cross and Blue Shield subscribers in their programs?

(Johnston Depo. Exh. 29, p. 5.) Johnston said "the real issue is not HCA, it is not Wesley . . . but who

do we align with while we still can and get a product with a price subscribers can afford," and "I don't think staff is acting on Wesley per se or HCA per se." (*Id.*, pp. 11, 14.) Following further discussion the committee voted "no" to the question posed, agreeing to terminate the existing Wesley contracting provider agreement effective December 31, 1985. (Stipulation x.) The Chairman of the BCBSK Board of Directors testified in his deposition:

> It was my perception that we were trying to preserve our fair share of the market, that we should take a stance of self-preservation against the dominant force that seems to be an adverse influence, or indirect, undeniable influence in the market in Wichita and surrounding areas. I think we have an obligation as a board member [sic] to preserve the interests of BCBS, to protect the subscribers of BCBS.
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> * * *
>
> I think they [HCA] were improperly invading the market. We could see an erosion of membership in our health maintenance organization. We could see the weakening of our position in that area due to their invasion into that health care field.

(Haas Depo., pp. 69-70.) As of August 29, 1985

Wesley had not done anything in dealing with BCBSK or its subscribers which threatened BCBSK; the decision to terminate the hospital "was not based on what they had done at that time, [but] more or less what their programs would do in the future." (*Id.*, pp. 71-73.) The cancellation of HCA was intended as "'a message to the provider community that the benefits of contracting [with BCBSK] are so great that the Blue Cross relationship should figure into their day to day as well as long range plans.'" (Manley Depo., p. 99; Depo. Exh. 10.) The letter notifying Wesley of its termination was prepared and sent the same day.

Neither Wesley nor HCA were consulted or advised of BCBSK's plans prior to the August 29 meeting. During the meeting John Knack was stationed in Wichita anticipating the committee's decision and preparing, with the public relations staffs of St. Francis and St. Joseph, to respond to press inquiries. (Knack Depo., pp. 58-62.) Notwithstanding an earlier promise to O'Brien, Wesley's representative on the Executive Committee, to withhold public release of the decision until O'Brien could return to Wichita, BCBSK issued its press release that afternoon. (*Id.*, p. 67.) The release explained the rationale for the termination as follows:

> In the past few months, HCA has clearly announced its intention to enter into all lines of insurance and become a direct competitor

> of [BCBSK]. Their recent purchase of Health Care Plus is clear evidence of this.

(Manley Depo. Exh. 1.) In a meeting with the BCBSK marketing staff in Wichita on August 30, Knack stated they had chosen to disassociate with Wesley for one reason: HCA, the owner of Wesley, Health Care Plus, and other clinics, plans to become a direct competitor of BCBSK. (Cox Depo., p. 65; Depo. Exh. 2.)

BCBSK, St. Francis and St. Joseph reached a firm commitment to establish the Kansas Health Plan HMO on or about September 1, 1985. (Mackey Depo., p. 62.)

During September officials of Wesley and HCA communicated with BCBSK officials a number of times, attempting to persuade them to reverse the termination decision. In a meeting on September 5, and in telephone conversations September 9 and 10, Wayne Johnston indicated BCBSK might be willing to reconsider if he received assurances HCA "would not be competing with us in that environment," assurances that HCA would agree not to market its new products in competition with BCBSK; he later indicated no inclination to reconsider because "I don't hear you say that you are not going to compete with Blue Cross." (Stipulations z, aa, bb; Dauner Depo., p. 175; Davis Depo., pp. 13-17; Johnston Depo., pp. 250, 257-58; Williamson Depo., p. 70.) At the September 5 meeting with Wesley officials, Johnston and Dauner related how they had been in

discussions with St. Joseph and St. Francis during the previous weeks and felt the need to work with those hospitals very closely and carefully to avoid those hospitals' alignment with another insurance carrier which might "squeeze" BCBSK out of the Wichita market. Johnston also stated: "You know that one of the two hospitals, one of those other two hospitals, are [sic] probably not going to be there in a few years anyway. At that point in time, maybe we can get back together." (Davis Depo., pp. 19-21.)

Wesley officials requested, and were reluctantly granted, permission to address the BCBSK Executive Committee at its September 19 meeting. Following Davis' remarks to the committee requesting reconsideration of its decision, Johnston told the committee:

> I'm more convinced than ever that our decision was a proper one. I'm convinced that HCA will be vertically integrated and believe this was demonstrated by the fact they [sic] have already purchased an HMO and their strategy is to compete with [BCBSK].

(Johnston Depo. Exh. 34, p. 11.) The committee voted to reaffirm the termination. (*Id.*, p. 24.) At the same meeting the committee approved the newly reduced MAPs for Wichita pursuant to the agreement reached with St. Francis and St. Joseph. (*Id.*, p. 23.) Prior to this time BCBSK had never

introduced revised MAPs other than on an annual basis. (Miller Depo., p. 191.)

Wesley responded to BCBSK's announcement by purchasing several newspaper advertisements in the Wichita Eagle-Beacon. In those advertisements, Wesley assured BCBSK subscribers that, notwithstanding BCBSK's action, Wesley would continue to accept Blue Cross reimbursement as payment in full and assist subscribers in claims processing. (Davis Depo., pp. 25-26.) Wesley has spent over $170,000 on its public relations campaign designed to minimize the impact of the announced termination. (Davis Depo., p. 26.)

BCBSK responded by running a full-page ad in the September 10, 1985 Wichita Eagle-Beacon. (Stipulation cc.) The ad, after announcing the termination decision, continued:

> Blue Cross and Blue Shield of Kansas will still have contracts with St. Francis, St. Joseph and Riverside Hospitals in Wichita as well as most acute care hospitals across the state. These contracts contain a unique "hold harmless" provision which protects Blue Cross and Blue Shield of Kansas subscribers. Our contracts with hospitals give our subscribers greater predictability of coverage. Subscribers do not have to worry about paying amounts over our allowances to Contracting Providers. They also know in advance what their out-of-pocket expenses

will be.

> Beginning January 1, 1986, the method of reimbursement for Wesley Medical Center will be different. Payment will be only to the Subscriber, rather than directly to Wesley.
>
> If Wesley's charges are more than Blue Cross of Kansas allowances to other hospitals for the same services, the subscriber will be responsible for the difference.

On approximately the same date, BCBSK issued to its subscribers a publication entitled "Healthplan," which contained the same statements as the September 10 Wichita Eagle-Beacon advertisement. (Stipulation dd; Johnston Depo. Ex. 33, p. 2.) In fact, Wesley did agree to the 20% reduced MAPs even though in many cases it meant providing services below Wesley's costs of operation. (Davis Depo., pp. 24-26; Stewart Depo., pp. 13-15.)

BCBSK also abandoned the Choice Care program in Wichita as a result of its decision to terminate Wesley, although Choice Care continues to operate successfully in other parts of Kansas. (Johnston Depo., p. 222; Dauner Depo., pp. 67, 80.)

The short term effects of the decision to terminate Wesley are clear. Wesley will lose the benefits associated with contracting status. (*Supra*, pp. 6-8.) The termination was designed to send a

"message" to other providers they could expect similar treatment if they decided to enter arrangements competing with BCBSK. (Morley Depo. Exh. 8; Sullivan Depo., pp. 121-22; Chase Depo., pp. 52, 56-57, 70-71, 83; Wilson Depo., pp. 39-45.) BCBSK faces the costs and consequences resulting when any hospital becomes a non-contracting provider. (*Supra*, p. 8.) In addition, BCBSK anticipates losing subscribers; in fact, in his deposition testimony Dauner stated he saw no benefits accruing to BCBSK over the next two or three years as a result of the decision. (Dauner Depo., pp. 158-59; Knack Depo., p. 198.) BCBSK rescinded its initial plans to terminate Wesley's lease on electronic data processing equipment and refuse to permit Wesley to submit claims on computer tape; Wesley will be permitted to make paperless claims submissions, but the change was made to ensure that decreasing BCBSK's paperless submissions "is in our best interest and is more harmful to Wesley" than to BCBSK. (Morley Depo. Exh. 10; Manley Depo., p. 102 & Depo. Exh. 11; Miller Depo. Exh. 9.) BCBSK also experienced significant resistance from its major employer groups, such as Boeing, Southwestern Bell, and the national Blue Cross Federal Employee Program. (Manley Depo., pp. 56-87; Depo. Exhs. 6 and 7.) HCP and New Century will be unable to compete with BCBSK on equal terms with St. Joseph, St. Francis and Riverside hospitals, and may face increased costs, both from those hospitals as a result of the drastic modifications to the CAP

contracts and from Wesley as a result of the termination. (Kilissanly Depo., pp. 46-49; Bugg Depo., pp. 97-99; Smith Depo., p. 29.)

The Suit

On November 12, 1985 plaintiffs filed a 17-count complaint against BCBSK. Counts I - III allege violations of Section 1 of the Sherman Act, 15 U.S.C. §1. Counts IV - VI allege violations of Section 2 of the Sherman Act, 15 U.S.C. §2. Counts VII - XVII are pendent state law claims, including allegations of state and common law antitrust violations, violations of public policy and defendant's enabling act, and claims of breach of contract and tortious interference. Plaintiffs request actual damages under Section 4 of the Clayton Act, 15 U.S.C. §15, and injunctive relief under Section 16 of the Clayton Act. 15 U.S.C. §26. (Rec. 1, 5-6.) Plaintiffs' motion for a preliminary injunction was brought to the Court's attention at a status conference November 21, 1985, but the parties mutually agreed Wesley's contracting provider agreement would remain in effect pending outcome of the suit, and the Court did not act on the requested injunction. (Memorandum Order, Nov. 22, 1985, Rec. 9.) Following the parties' agreement St. Joseph, with the support of St. Francis, sought to delay implementation of the reduced MAPs because Wesley would not be terminated effective January 1, 1986, and there would not be the change in patient volume they anticipated. (Sullivan Depo., pp. 63-66;

Knack Depo., p. 213.) BCBSK refused the request, holding the hospitals to the CAP agreements they signed. (Knack Depo., p. 214.)

BCBSK now seeks summary judgment on the entire complaint for three reasons: plaintiffs HCP, New Century and Reazin lack standing; Wesley has no viable federal antitrust claims; and the pendent state claims are controlled by two decisions of the Kansas Supreme Court.

STANDING

The first six counts of the complaint are plaintiffs' federal antitrust claims under Sections 1 and 2 of the Sherman Act. Section 1 provides:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade among the several States . . . is declared to be illegal . . . .

15 U.S.C. §1. Section 2 provides:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several states . . . shall be deemed guilty of a felony . . . .

15 U.S.C. §2. Count I of the complaint alleges a

restraint of trade by BCBSK, in concert with St. Francis, St. Joseph and Riverside hospitals, in unlawfully terminating Wesley's contract and refusing to deal with Wesley as a participating hospital. Count II alleges a further restraint of trade in violation of §1 by BCBSK, through terminating Wesley and entering contracts with those hospitals, pursuant to which they or other providers of health care will boycott or otherwise refuse to deal with HCP, New Century, and other private health care financing organizations seeking to compete with BCBSK. Count III alleges those same acts are a restraint of trade violating §1 because the other health care providers therein agreed not to compete with BCBSK. Count IV alleges a violation of §2 because BCBSK, in terminating Wesley's contract, committed the offense of monopolization. Count V also alleges a violation of §2 because BCBSK is engaged in an attempt to monopolize. Count VI alleges BCBSK is engaged in a conspiracy or conspiracies to monopolize in violation of §2.

Section 4 of the Clayton Act authorizes private damage suits by persons injured in their "business or property by reason of anything forbidden in the antitrust laws. . . ." 15 U.S.C. §15. Section 16 of the Clayton Act authorizes private suits for injunctive relief "against threatened loss or damage by a violation of the antitrust laws . . . . " 15 U.S.C. §26. The remedies under the two sections, and therefore their standing requirements, are distinct.

Section 4 of the Clayton Act

Read literally, Section 4 encompasses any harm even indirectly attributable to any antitrust violation. Congress intended the protections of the antitrust laws to extend to a broad range of potential victims. *Blue Shield of Virginia v. McCready*, 457 U.S. 465, 472 (1982). But there is "a point beyond which the wrongdoer should not be held liable." *Illinois Brick Co. v. Illinois*, 431 U.S. 720, 760 (1977) (Brennan, J., dissenting). "It is reasonable to assume that Congress did not intend to allow every person tangentially affected by an antitrust violation to maintain an action to recover threefold damages for the injury to his business or property." *McCready*, 457 U.S. at 477.

In order to maintain an antitrust action plaintiffs must show more than injury linked to a violation of the antitrust laws. Plaintiffs must prove "antitrust injury", defined as "injury of the type the antitrust laws were intended to prevent and that flows from that which makes defendants' acts unlawful." *Brunswick v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477 (1977). In *Brunwick* plaintiffs sued under Section 7 of the Clayton Act, claiming defendant Brunswick's acquisition of rival bowling alleys would tend to lessen competition. Damages claimed were lost profits plaintiffs would have realized had the competitors been allowed to go out of business. The Supreme Court rejected plaintiffs' position, finding

they were actually complaining about increased competition and their inability to profit from increased market concentration. *Brunswick*, 429 U.S. at 488. The court disagreed with the Ninth Circuit's ruling any loss "causally linked" to "the mere presence of a violator in the market" was compensable. *Id.* at 487, *quoting* 523 F.2d at 272-73. The court concluded that to permit plaintiffs to proceed on such a theory would separate antitrust recovery from the promotion of competition, the singular purpose of the antitrust laws. *Id.* at 490. This principle was most recently applied in *Matsushita Elec. Ind. Co. v. Zenith Radio*, 475 U.S. ___, 89 L.Ed.2d 538, 550, 106 S.Ct. 1348 (1986), holding respondents could not recover for petitioners' alleged conspiracy to charge higher than competitive prices; even though such conduct would violate the Sherman Act respondents as petitioners' competitors, stood to benefit from any conspiracy to raise the market price of the product.

In *Blue Shield of Virginia v. McCready*, 457 U.S. 465 (1982), defendant Blue Shield refused to reimburse its subscribers for services obtained from a psychologist, although covering services provided by psychiatrists. The issue was whether an individual subscriber who had been denied reimbursement for psychological services had standing under Section 4 to sue Blue Shield for an unlawful conspiracy to restrain competition in the psychotherapy market. The court concluded she did. 457 U.S. at 484.

The *McCready* analysis began with the principle Section 4 "'does not confine its protection to consumers, or to purchasers, or to competitors, or to sellers . . . . The Act is comprehensive in its terms and coverage, protecting all who are made victims of the forbidden practices by whomever they may be perpetrated.'" 457 U.S. at 472, *quoting Mandeville Island Farms, Inc. v. American Crystal Sugar Co.*, 334 U.S. 219 (1948). Section 4 is applied in accordance with its plain language and its broad remedial and deterrent objectives. However, the Section 4 remedy is limited to particular classes of persons. Thus, a state may not sue in its *parens patriae* capacity for damages to its general economy because consumers themselves may sue for injuries to business or property. This limitation is designed to avoid double recovery. *Id.* at 473, *citing Hawaii v. Standard Oil Co.*, 405 U.S. 251 (1972). The Section 4 remedy is also limited to particular forms of injury. In *Illinois Brick Co. v. Illinois*, 431 U.S. 720 (1977), recognizing the unacceptable risk of duplicative recovery implicated by allowing both direct and indirect purchasers of a product to sue, the court held an indirect purchaser may not claim damages from an antitrust violator measured by the amount of overcharge passed on, concluding direct purchasers are the injured parties who as a group were most likely to press their claims with the vigor the Section 4 treble damage remedy was intended to promote. In *McCready*, the court noted:

> If there is a subordinate theme to our opinions in Hawaii and Illinois Brick, it is that the feasibility and consequences of implementing particular damages theories may, in certain limited circumstances, be considered in determining who is entitled to prosecute an action brought under §4. Where consistent with the broader remedial purposes of the antitrust laws, we have sought to avoid burdening §4 actions with damages issues giving rise to the need for "massive evidence and complicated theories," where the consequence would be to discourage vigorous enforcement of the antitrust laws by private suits. Thus we recognized that the task of disentangling overlapping damages claims is not lightly to be imposed upon potential antitrust litigants, or upon the judicial system. In addition, while "[d]ifficulty of ascertainment [should not be] confused with right of recovery," §4 plainly focuses on tangible economic injury. It may therefore be appropriate to consider whether a claim rests at bottom on some abstract conception or speculative measure of harm.

457 U.S. at 475, n. 11 (citations omitted). The court found McCready's claim presented no possibility of imposing duplicative damages against defendants because plaintiff had already paid the psychologist who therefore suffered no injury, and because the subscriber, rather than her employer who purchased

the Blue Shield plan, was out of pocket as a consequence of plan's failure to pay benefits. *Id.*

Turning to the question whether plaintiff's injury was too remote to justify standing, the court resorted to the tort concept of proximate cause, and stated the proper focus was on (1) the physical and economic nexus between the alleged antitrust violation and harm to plaintiff, and (2) more particularly, the relationship of the injury alleged with those forms of injury about which Congress was likely to have been concerned in making defendants' conduct unlawful and in providing a private remedy under Section 4. 457 U.S. at 478. On the question of nexus, Blue Shield argued that because the alleged conspiracy was directed at psychologists rather than subscribers, only the psychologists had standing. The court soundly rejected that notion, concluding plaintiff's injury was not "remote" simply because the goal of the conspirators was directed elsewhere:

> The availability of the § 4 remedy to some person who claims its benefit is not a question of the specific intent of the conspirators. Here the remedy cannot reasonably be restricted to those competitors whom the conspirators hoped to eliminate from the market. McCready claims that she has been the victim of a concerted refusal to pay on the part of Blue Shield, motivated by a desire to deprive psychologists of the patronage of Blue Shield subscribers. Denying reimbursement to subscribers for the

> cost of treatment was the very means by which it is alleged that Blue Shield sought to achieve its illegal ends. The harm to McCready and her class was clearly foreseeable; indeed, it was a necessary step in effecting the ends of the alleged illegal conspiracy. Where the injury alleged is so integral an aspect of the conspiracy alleged, there can be no question but that the loss was precisely "'the type of loss that the claimed violations. . . would be likely to cause.'" Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc., 429 US, at 489, 50 L Ed 2d 701, 97 S Ct 690, quoting Zenith Radio Corp. v. Hazeltine Research, Inc., 395 US 100, 125, 23 L Ed 2d 129, 89 S Ct 1562 (1969).

457 U.S. at 479 (footnote omitted). The court also rejected Blue Shield's argument the Section 4 remedy was unavailable to plaintiff because she was not an economic actor in the market restrained. "As a consumer of psychotherapy services entitled to financial benefits under the Blue Shield plan, we think it clear that McCready was 'within that area of the economy . . . endangered by [that] breakdown of competitive conditions' resulting from Blue Shield's selective refusal to reimburse." 457 U.S. at 480-81, *quoting In re Multidistrict Vehicle Air Pollution M.D.L. No. 31*, 481 F.2d 122, 129 (9th Cir. 1973). Concerning the second factor of the remoteness inquiry, the manner in which plaintiff's alleged injury reflected Congress' core concerns in prohibiting this

conduct, Blue Shield argued her injury did not reflect any anticompetitive effect of the alleged boycott because she had never faced or paid an increased price for psychotherapy services. That argument was also rejected. The court reaffirmed its statement in *Brunswick* a Section 4 plaintiff need not "'prove any actual lessening of competition in order to recover. [C]ompetitors may be able to prove antitrust injury before they are actually driven from the market and competition is thereby lessened.'" 457 U.S. at 482, *quoting* 429 U.S. at 489 n. 14. The court concluded an increase in price resulting from a dampening of competitive conditions was not to be the sole injury remediable under Section 4. Although plaintiff McCready was not an economic competitor, the court determined her injury was "inextricably intertwined" with the injury the conspirators sought to inflict on psychologists and the psychotherapy market, "'flow[ing] from that which makes defendants' acts unlawful,'" and falling squarely within the area of congressional concern. 457 U.S. at 484, *quoting Brunswick* at 489.

One of the most important pronouncements from the Supreme Court on the question of standing under Section 4 is *Associated General Contractors v. Cal. State Council of Carpenters*, 459 U.S. 519 (1983). Plaintiff union alleged that in violation of the antitrust laws defendant multiemployer association coerced some of its members and certain third parties to enter business relationships with

nonunion firms, which was claimed to have adversely affected the trade of certain unionized forms and thereby the business activities of the union. The issue was whether the complaint sufficiently alleged injury to the union's business or property to give it standing to recover damages under Section 4. *Associated General*, 459 U.S. at 521. Resorting not to the broad language of Section 4 but to an evaluation of plaintiffs' harm, the alleged wrongdoing by defendants, and the relationship between them, the court concluded the union lacked standing. *Id.* at 535, 545-46. In particular, the court identified six factors to be considered in evaluating standing: (1) the causal connection between the alleged antitrust violation and the harm; (2) improper motive or intent of defendants; (3) whether the claimed injury is one sought to be redressed by antitrust damages; (4) the directness between the injury and the market restraint resulting from the alleged violation; (5) the speculative nature of the damages claimed; and (6) the risk of duplicate recoveries or complex damage apportionment.

The causal connection between the violation alleged in that case and the harm to plaintiffs was weak, the court reasoned, because even assuming the coercion directed by defendants at third parties to restrain the trade of certain unionized contractors and subcontractors may have been unlawful, it did not follow that still another party, the union itself, was a "person" thereby injured. *Associated General*,

459 U.S. at 529. Allegations of improper motive or intent on the part of defendants, though supporting a damage claim under Section 4, are not a panacea shielding a complaint from dismissal. *Id.* at 537. But in a footnote to the discussion of that factor, important for our present purposes, the court stated a defendant's specific intent may be relevant to the question of standing.

> [T]here no doubt are cases in which such an allegation would adequately support a plaintiff's claim under §4. *Cf.* Handler . . . (specific intent of defendant to cause injury to a particular class of persons should "ordinarily be dispositive" in creating standing to sue); Lytle & Purdue, . . . (suggesting that standing in a group boycott situation should be based on the purpose of the boycott).

Id., n. 35, *quoting* Handler, The Shift from Substantive to Procedural Innovations in Antitrust Suits, 71 Colum. L. Rev. 1, 30 (1971); and Lytle & Purdue, Antitrust Target Area Under Section 4 of the Clayton Act: Determination of Standing in Light of the Alleged Antitrust Violation, 25 Am. U.L. Rev. 795, 814-16 (1976).

The court in *Associated General* next determined the third factor weighed in defendants' favor because the injury claimed by the union was not one sought to be redressed under the antitrust

laws. The Sherman Act is designed to assure customers the benefits of price competition, and cases emphasize the central interest in protecting the economic freedom of participants in the market. 459 U.S. at 538. The union was neither a consumer nor a competitor in the market in which trade was allegedly restrained, and there was a strong inference the union's interests in enhancing its members' earnings would be disserved or harmed by enhanced, uninhibited competition among employers striving to reduce costs. Against its labor background, the union in its capacity as a bargaining representative will frequently not be part of the class the Sherman Act was designed to protect. *Id.* at 539-40. The fourth factor, the directness between the injury and the market restraint, was weak. The court noted defendants' alleged coercion against contracting parties to direct business away from union contractors had insignificant effects on the union because it was neither a participant in the market for construction contracts or subcontracts, nor a direct victim of defendants' coercive practices. In this context, however, the court expressly reserved decision on whether a direct victim of a boycott who suffers a type of injury unrelated to antitrust policy may recover damages when the ultimate purpose of the boycott is to restrain competition in the relevant economic market. *Id.* at 540, n. 44.

The fifth and sixth factors in *Associated General*, the speculative nature of plaintiffs' damages and the

risk of duplicative recoveries or complex damage apportionment, were related. The complaint alleged the union suffered unspecified injuries in its business activities, but the court found it obvious such injuries were only the indirect result of whatever harm may have been suffered by certain construction contractors and subcontractors. If either those firms or the direct victims of defendants' coercion had been injured, their injuries would be direct, and under *McCready* they would have the right to maintain their own treble damages actions against defendants.

> The existence of an identifiable class of persons whose self-interest would normally motivate them to vindicate the public interest in antitrust enforcement diminishes the justification for allowing a more remote party such as the Union to perform the office of a private attorney general. Denying the Union a remedy on the basis of its allegations in this case is not likely to leave a significant antitrust violation undetected or unremedied.

459 U.S. at 542 (footnote omitted). Partly because it was indirect and partly because the effects on the union may have been produced by independent factors, the court found plaintiffs' damage claim highly speculative contrary to the dictates of *McCready*. *Id.* at 542-43. Also flowing from the

indirect nature of plaintiff's damages was the need to avoid the risk of duplicate recoveries and the danger of complex apportionment of damages. Were plaintiff permitted to proceed with the complaint, the court noted, the district court would face problems of identifying damages and apportioning them among directly victimized contractors and indirectly affected employees and union entities. It would further be necessary for the court to determine the extent to which coerced firms diverted business from union subcontractors, and then the extent to which the subcontractors absorbed that damage or passed it on to employees by shortening personnel, hours or wages. *Id.* at 545. All of these problems, inferentially, would be avoided by relying on the more direct victims of defendants' allegedly illegal conduct to seek the Section 4 remedy.

The circuit courts of appeal have not been uniform in fashioning tests of antitrust standing under Section 4 in light of *McCready* and *Associated General. See generally Amey, Inc. v. Gulf Abstract & Title, Inc.*, 758 F.2d 1486, 1495 (11th Cir. 1985), *cert. denied* 89 L.Ed.2d 912, 106 S.Ct. 1513 (1986) (survey of various circuits). The Fifth and Eleventh Circuits continue to employ a "target area" test requiring plaintiff to show he is within that sector of the economy threatened by the breakdown of competition; the court first identifies the area of economy threatened by the alleged anticompetitive conduct, and then determines whether plaintiff's

injury is within that target area or if the defendant "aimed" at the plaintiff. *Amey*, 758 F.2d at 1496; *Walker v. U-Haul Company of Mississippi*, 734 F.2d 1068 (5th Cir. 1984). A recent decision by the Seventh Circuit employs a *Brunswick* analysis sharing elements of the target area test. *Local Beauty Supply, Inc. v. Lamaur, Inc.*, __ F.2d __, 1986-1 Trade Cases (CCH) ¶67,040 (7th Cir. 1986) (distinguishing *Associated General* as dealing with remoteness). The Third and Ninth Circuits have indicated close adherence to the factors identified in *Associated General*. *Gregory Marketing Corp. v. Wakefern Food Corp.*, 787 F.2d 92 (3d Cir. 1986); *Exhibitors Service, Inc. v. American Multi-Cinema, Inc.*, __ F.2d __, 1986-1 Trade Cases (CCH) ¶67,067 (9th Cir. Apr. 25, 1986); and *Bhan v. NME Hospitals, Inc.*, 772 F.2d 1467 (9th Cir. 1985).

It appears the First and Fourth Circuits and our own Tenth Circuit have not addressed the question of Section 4 standing in light of *McCready* and *Associated General*. Little direction is gleaned from *Monfort of Colorado, Inc. v. Cargill, Inc.*, 761 F.2d 570 (10th Cir. 1985), *cert. granted* 88 L.Ed.2d 763, 106 S.Ct. 784 (1986). The question in *Monfort* involved plaintiff's standing to seek injunctive relief under Section 16. Although the court acknowledged these two Supreme Court opinions it stated the concerns with restricting Section 4 cases, arising in part because of the peculiar risks of unrestrained

treble damage claims, are of little consequence in a Section 16 case. 761 F.2d at 574.

In *Associated General*, the Supreme Court acknowledged the various tests articulated by the circuit courts but stated "they may lead to contradictory and inconsistent results . . . . In our view, courts should analyze each situation in light of the factors set forth" in that case. 459 U.S. at 536 n. 33. For that reason and because there is no other authority on the question in this circuit, we will apply the six *Associated General* factors in this case to determine plaintiffs' standing under Section 4. In so doing, we agree with the Ninth Circuit's observations the Supreme Court did not specifically state in *Associated General* a plaintiff must satisfy *all* those factors or any particular one, while recognizing the inquiry whether plaintiff suffered injury of a type the antitrust laws were designed to prevent is a factor of "tremendous significance." *Bhan v. NME Hospitals, Inc.*, 772 F.2d 1467, 1470 n.3 (9th Cir. 1985).

Plaintiffs allege HCP will be placed at a substantial competitive disadvantage in, and possibly excluded from, the Sedgwick County health care financing market as a result of BCBSK's termination of Wesley and the particular terms on which BCBSK revised its contracting provider agreements with the three remaining Wichita hospitals. BCBSK argues HCP lacks standing for three reasons. First, HCP has not been excluded from the market; it was under contract with the other three Wichita hospitals

at the time of Wesley's termination, and all of those contracts are still in effect with no changes in their terms. Second, HCP's injuries are remote and speculative, involving an "attenuated" relationship between higher costs for HCP which may be passed on to it if Wesley suffers decreasing occupancy rates from the loss of BCBSK subscribers as patients, resulting in higher costs and capitation rates. Third, defendant argues HCP actually stands to benefit from the proposed termination by gaining as new subscribers former BCBSK policyholders who prefer Wesley's hospital services. Plaintiffs respond HCP's injuries will result from difficulties in enrolling providers, and the likelihood of increased costs both from Wesley as a result of the termination, and other Wichita hospitals as a result of the drastic reduction in BCBSK's MAPs. Further, plaintiffs allege HCP and New Century were the direct targets of BCBSK's anticompetitive conduct; the termination of Wesley was undertaken not to harm the hospital but to deter the development of alternate health care delivery systems competing with BCBSK. Finally, they claim there is a serious dispute over whether HCP actually stands to benefit from defendant's conduct by gaining as members former BCBSK subscribers.

Even a cursory review of *Associated General* convinces this Court HCP is a proper party. BCBSK undertook the proposed termination of Wesley as a contracting provider because it did not want to do business with competitors. Wesley is not one of BCBSK's competitors; HCP and New Century are.

Plaintiffs correctly argue HCP and New Century are the direct targets of defendant's conduct. A detailed application of the *Associated General* factors might well be unnecessary in light of the Supreme Court's statement a defendant's specific intent "to cause injury to a particular class of persons 'should ordinarily be dispositive' in creating standing to sue." 459 U.S. at 537 n. 35 (citations omitted).

But even a detailed analysis of those factors in this case only reinforces the conclusion HCP has standing. The causal connections between the alleged antitrust violations and HCP's harm, and between the market restraint and HCP's injury, are strong. HCP does not occupy the remote status of the union in *Associated General*; rather it is the direct victim of the allegedly unlawful conduct as were the unionized contractors and subcontractors in that case, the participants in the relevant market. The Supreme Court expressly stated that both the coerced parties and direct victims, if injured, would have a right to maintain suit for damages; that was one of the principal reasons the union itself was found to lack standing. 459 U.S. at 541.

Further, HCP's damages are of the type sought to be redressed by antitrust laws, and in the particular factual context of this case are not sufficiently speculative to warrant the conclusion it lacks standing. Unlike the plaintiffs in *Brunswick* and *Associated General*, when the evidence in this case is taken in its most favorable light, HCP is not

seeking damages as a consequence of acts that will unequivocally enhance competition in the market.

Based on the evidence now before the Court, there is a distinct possibility the jury may well conclude that if any party is complaining about increased competition in the market, it is BCBSK itself, not plaintiffs. True, BCBSK argues its conduct will enhance competition by reducing costs to consumers and making available a "new" health care financing package in the form of what it styles as a "preferred provider agreement" with the other three Wichita hospitals. But that conclusion is hotly disputed. Even accepting as true BCBSK's assessment of the evidence (which we do not for purposes of summary judgment), it ignores the facts that in providing this "new" product BCBSK removed from the market its tremendously popular traditional indemnity insurance plan providing coverage for service at all four Wichita hospitals, and abandoned the Choice Care program in Wichita while Choice Care has been successful and well received elsewhere in Kansas. In addition, whether the "new" product will actually reduce costs to consumers involves no small degree of speculation itself. In the myriad depositions and reams of documents presented, the Court finds no evidence whatsoever BCBSK has guaranteed, or committed itself to, a reduction in subscribers' rates as a result of the discounted MAPs. Finally, HCP argues, not implausibly, that BCBSK's termination of Wesley and entrance into highly favorable contracts with the other Wichita hospitals

can only result in higher costs at all the hospitals, which necessarily will be shifted elsewhere in the market in which HCP is a principal purchaser of those services and competitor of BCBSK. An increase in price resulting from a dampening of competitive market forces is "assuredly one type of injury for which Section 4 potentially offers redress." *McCready*, 457 U.S. at 482-83, *citing Reiter v. Sonotone Corp.*, 442 U.S. 330 (1979). Nor may defendant discount plaintiffs' damages claim to the extent overcharges might be passed on to HCP's subscribers. *Hanover Shoe, Inc. v. United Shoe Machinery Corp.*, 392 U.S. 481 (1968).

Particular attention must be given to defendant's argument HCP's damages, as well as those of New Century and Reazin, are "speculative". The case is presently before the Court in a unique posture because of the parties' voluntary agreement to preserve the status quo, continuing to abide by the terms of the Wesley/BCBSK contracting provider agreement pending the outcome of this suit. The Court perceives the case as primarily a declaratory judgment action which will be tried to the jury to determine whether what is now the proposed termination of Wesley's contract, along with the formation and effect of the revised BCBSK contracting provider agreements with the remaining Wichita hospitals, would violate the antitrust laws if carried out. To that extent all plaintiffs' claimed injuries and damages are "speculative", but of course

BCBSK cannot make any such argument. Consistent with the manner in which this case will be presented to the jury, the Court looks not to the existing situation to determine the merit of plaintiffs' claimed damages, but to their merit if BCBSK were to carry out its allegedly anticompetitive conduct.

Viewed in this light, the evidence is unconvincing HCP's damages are speculative to the degree warranting a determination it lacks standing. The union's injuries in *Associated General* were unspecified, the indirect result of whatever harm might have been suffered by the direct victims of defendants' coercion, and very possibly the result of independent factors. 459 U.S. at 542-43. To the extent HCP's damages are "unspecified", that is largely the result of the parties' voluntary maintenance of the status quo, by reason of which defendant's conduct has not yet had a measurable impact on the market. But the injuries HCP claims it would sustain if the conduct occurred are injuries of a direct victim and not likely the result of independent factors.

The last *Associated General* standing factor is the risk of duplicate recoveries and the danger of complex apportionment of damages. Here also HCP's status as a direct victim of defendant's conduct mitigates these concerns. The Court rejects defendant's argument Wesley's presence in this litigation adequately protects HCP's interests. The antitrust allegations in the complaint are directed not only at the termination of Wesley as a contracting

provider, but also against the effects of the modified CAP contracts BCBSK entered into with the other Wichita hospitals. Clearly, those contracts and any anticompetitive effects are directed not against Wesley but against BCBSK's competitors, including HCP. The risk of duplicate recoveries arises from the multifaceted conduct of defendant, and any danger of complex apportionment of damages arises from the separate and distinct injuries claimed, not because there are others in the chain of causation with more persuasive Section 4 claims which could be brought against BCBSK.

The Court concludes HCP is a proper party with standing to sue under Section 4. *Associated General* stands for little if not the overriding principle it is the direct victims of anticompetitive conduct which should be relied on to press their Section 4 claims with vigor. HCP is such a party.

New Century contends it will also be placed at a competitive disadvantage and possibly excluded from the Sedgwick County health care financing market as a result of defendant's conduct. But New Century has not, and currently is not, selling its insurance products in this market, although expecting regulatory approval at any time. Defendant insists this fact alone warrants denial of standing because New Century cannot plausibly argue it has been precluded from the market by reason of BCBSK's conduct. Plaintiffs respond with case authority holding a competitor need not be engaged in an ongoing business to have standing, that it is sufficient

if the competitor manifests his intent to enter the market and preparedness to do so, as has New Century.

The Court concludes the *Associated General* factors weigh heavily against granting New Century standing. The causal connections between the alleged antitrust violations and New Century's harm, and between its injury and the market restraint, are severely weakened by the fact New Century is merely a prospective competitor. But even assuming it will suffer an "antitrust injury" sufficient to otherwise warrant standing (it, as HCP, would certainly be a direct victim of defendant's conduct), the risk of duplicate recoveries and the danger of complex damage apportionment are to the degree justifying denying New Century Section 4 standing. New Century has no existing business relations with Wesley. If and when New Century receives regulatory approval to sell its insurance products in Kansas, those products will be marketed not by New Century itself but by HCP. Although it will possess separate products, for standing purposes New Century's position is fairly indistinguishable from that of HCP. To allow both to proceed to the jury with their antitrust claims runs the risk of permitting duplicate recovery from BCBSK for what is singular conduct as against its competing insurance carriers. Further, the jury would be required to determine to what extent HCP absorbed its damages, passed the losses on to its own products, passed it on to New Century products, or passed it on in combination,

and then the extent to which New Century was damaged. Under these circumstances the Court concludes that between New Century and HCP, the latter is certainly the more direct victim, and in the interest of keeping what is already a highly complex antitrust action manageable for both the Court and the jury, HCP's presence and standing will adequately protect New Century's interests and remedy any violations thereof.

Plaintiff Reazin's sole connection with this case, defendant argues, is that he is on the medical staff of Wesley. In his deposition Dr. Reazin testified BCBSK's termination of Wesley might force him to join other hospital staffs if his BCBSK patients sought treatment there, that he would be forced into additional time and expense to satisfy those patients' needs, and that the termination might have a disadvantageous impact on his resources remaining at Wesley. (Reazin Depo., p. 16.) Defendant also argues Reazin lacks standing in part because neither he, nor Sedgwick County doctors in general, were the target of defendant's conduct.

The Court agrees Reazin lacks Section 4 standing. Even assuming his injuries are "antitrust" in nature, the chains of causation between his injuries, and the alleged violations and the market restraint, are sufficiently attenuated to warrant the conclusion he is not a proper party. Reminiscent of the union's arguments in *Associated General*, Reazin argues he will be injured *if* BCBSK policyholders, themselves indirect victims of defendant's conduct,

demand he treat them at other hospitals, and if the injuries suffered by Wesley, a direct victim, translate into staff and equipment reductions. *Associated General* expressed an overwhelming preference for permitting the direct victims of antitrust violations to sue, rather than persons in the remote status of Reazin. Finally, and for the same reasons, allowing Reazin to present his claims to the jury would entail a high risk of duplicate recoveries and a danger of extremely complex apportionment of damages.

Reazin's status as a BCBSK subscriber provides him no solace under the facts of this case. Unlike the plaintiff in *Blue Shield of Virginia v. McCready*, whose damages could be calculated "to the penny," Reazin does not claim to have already suffered direct, personal financial loss as a consequence of defendant's conduct. Defendant BCBSK is granted summary judgment on the Section 4 claims of New Century and Dr. Reazin. The direct victims of defendant's conduct, Wesley and HCP, are present in this lawsuit vindicating the public interest in antitrust enforcement. Denying New Century and Reazin remedies on the basis of their allegations will not leave significant antitrust violations undetected or unremedied.

Section 16 of the Clayton Act

Section 16 of the Clayton Act, permitting injunctive relief, involves traditional principles of

equity. The remedy "is flexible and capable of wise 'adjustment and reconciliation between the public interest and private needs. . . .'" *Zenith Radio Corp. v. Hazeltine Research, Inc.*, 395 U.S. 100 (1969) (citation omitted). The Tenth Circuit detailed the requirements for standing under Section 16 in *Monfort of Colorado, Inc. v. Cargill, Inc.*, 761 F.2d 570 (10th Cir. 1985), *cert. granted* 88 L.Ed.2d 763, 106 S.Ct. 784 (1986). Section 4 suits may be brought only by persons who are injured by the allegedly unlawful conduct, but in Section 16 injunction cases courts do not require proof of actual injury because they need not calculate damages. *Monfort*, 761 F.2d at 573. Plaintiffs in a Section 16 case need only prove a causal connection between their threatened injuries and the putative antitrust violations; once they surmount the causation hurdle they have standing to seek an injunction. *Id.* at 574, *citing Brunswick*, 429 U.S. 477 (1977). Relying on *McCready* and *Associated General*, the court stated the causation inquiry is similar to a proximate cause analysis under tort law; the question is whether the alleged antitrust violation and its consequences are a proximate cause of plaintiff's threatened injury. *Id.* Plaintiff Monfort, a direct horizontal competitor of defendants, relied on the theory defendant's proposed acquisition of another competitor would enable defendant to engage in predatory pricing for a period of time, driving others out of the market, after which defendant would then be able to charge

monopoly prices. *Id.* at 575. The court declined to embrace defendant's theory predatory pricing "is just true competition," noting courts continue to find predatory pricing, when proved, violates the antitrust laws. *Id.* It found that even though there remained a question whether the harm would arise (i.e., defendant's success in the undertaking), plaintiff presented a plausible theory of how it would be injured by the putative violation, a theory of injury logically related to the harm caused by an increased concentration of economic power in defendant. Concluding "the causal connection will exist if the ultimate injury materializes," the court held plaintiff had Section 16 standing. *Id.* at 576-77.

There is no challenge to Wesley's standing under Sections 4 and 16. We have concluded HCP possesses standing under Section 4; *a fortiori*, HCP has standing under Section 16. The question is whether New Century and Reazin, found to lack standing under Section 4, nevertheless have standing under Section 16. Plaintiffs who lack standing to seek damages may nevertheless have sufficient standing to seek injunctive relief. *Brunswick*, 429 U.S. at 491; *Monfort*, 761 F.2d at 573.

New Century is a direct horizontal competitor of defendant BCBSK, as is HCP. Both HCP and New Century are the direct and intended victims of the putative antitrust violations by defendant. The Court is satisfied that if the ultimate injuries to these plaintiffs materialize, including the shifting of costs

by other hospitals and the exclusion from the health care financing market, there will be a causal connection between these antitrust injuries and the alleged antitrust violations. New Century was determined to lack Section 4 standing principally because of the risk of duplicate recoveries and the danger of complex apportionment of damages, neither of which have any consequence in the question of standing under Section 16. Nor is the fact New Century has yet to enter the relevant market significant. Section 16 does not require actual injury and therefore does not foreclose antitrust claims for which the injury is yet to occur. *Zenith Radio Corp. v. Hazeltine Research, Inc.*, 359 U.S. 100 (1969); *Monfort*, 761 F.2d at 573. The Court concludes New Century has standing under Section 16.

In his professional capacity Dr. Reazin cannot surmount the causation hurdle. His injuries of additional time and expense may occur only if BCBSK subscribers, the indirect victims of the putative antitrust violations, demand he provide service to them at hospitals other than Wesley. The possible impact on his resources remaining at Wesley may occur only if Wesley, a direct victim, first suffers losses and then passes them along as reductions in staff and/or facilities. But in his personal capacity as a BCBSK subscriber, Reazin may be injured in the form of liability for excess costs at Wesley if the alleged antitrust violations occur. If this ultimate injury materializes, there will be the same causal

connection between the injury and the antitrust violations that existed in *McCready*. The Court concludes Reazin has standing under Section 16 to seek injunctive relief against that possibility.

Defendant BCBSK is denied summary judgment on the Section 16 injunctive relief claims of plaintiffs HCP, New Century and Reazin.

PLAINTIFFS' FEDERAL ANTITRUST CLAIMS

Section 1 of the Sherman Act.

Section 1 of the Sherman Act prohibits "every contract, combination . . ., or conspiracy, in restraint of trade. . . ." Plaintiffs claim in Counts I - III of their complaint defendant BCBSK has violated Section 1 by restraining trade in unlawfully terminating the contract with, and refusing to deal with, Wesley; it has contracted, combined or conspired with the other Wichita hospitals to boycott HCP; and it has contracted, combined or conspired with those same hospitals to refrain from competing with BCBSK in the health care financing market. Defendant seeks summary judgment on these claims, arguing first the termination of Wesley's contract was a unilateral decision by defendant not undertaken in agreement with others, and therefore no violation of Section 1. Alternatively, BCBSK argues that even if there is found to be an agreement, its conduct and the consequences of the agreement are neither a per se antitrust violation nor a violation under the rule

of reason.

Summary judgment may not be granted when a genuine issue of material fact is presented to the trial court. The evidence must be received in the light most favorable to the party against whom the judgment is sought, and factual inferences tending to show triable issues must be resolved in favor of the existence of those issues. Generally, summary judgment should be used sparingly in antitrust litigation. *Poller v. Columbia Broadcasting System, Inc.*, 368 U.S. 464., (1962); *Instructional Systems Development Corp. v. Aetna Casualty & Surety Co.*, __ F.2d __, No. 82-2105, slip op. at 7 (10th Cir. Mar. 31, 1986). This is particularly true in cases of novel antitrust claims. *White Motor Co. v. United States*, 372 U.S. 253 (1963); *Ratino v. Medical Service of Dist. of Columbia*, 718 F.2d 1260 (4th Cir. 1983).

-Agreement-

Section 1 of the Sherman Act does not proscribe independent action. Thus a manufacturer generally has a right to deal, or refuse to deal, with whomever it likes, so long as it does so independently. *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752 (1984); *United States v. Colgate & Co.*, 250 U.S. 300 (1919). However, the high value placed on the right to refuse to deal with others does not mean that right is unqualified.

Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S. __, 86 L.Ed.2d 467, 105 S.Ct. 2847 (1985). In *Aspen Skiing*, plaintiff was allowed to recover under both Sections 1 and 2 of the Sherman Act for a monopolist's unilateral decision to terminate a joint product where the decision was designed to make an important change in the character of the market. 86 L.Ed.2d at 481.

To create a jury issue on whether a defendant was party to an agreement or conspiracy prohibited by the antitrust laws, plaintiffs must produce evidence tending to prove defendant and other parties had a conscious commitment to a common scheme designed to achieve an unlawful objective. *Black Gold, Ltd. v. Rockwool Industries, Inc.*, 732 F.2d 779 (10th Cir. 1984), *cert. denied* 83 L.Ed.2d 113, 105 S.Ct. 178 (1985), *citing Monsanto*, 465 U.S. at 764. But the *Monsanto* requirement indicates no retreat from cases holding that a combination occurs between a seller and buyers whose acquiescence in the seller's firmly enforced restraints was induced by the communicated danger of termination. *Black Gold, id.* at 780, *citing Perma Life Mufflers v. International Parts Co.*, 392 U.S. 134 (1968). An insurer such as defendant may make a unilateral decision of the standard terms on which it will deal, and where that decision is not accompanied by a showing of concerted action or abuse of monopoly power, there is no violation of Section 1. *Glen Eden Hosp. v. Blue Cross & Blue Shield of Michigan*, 740

F.2d 423 (6th Cir. 1984).

Plaintiffs' evidence shows no less than 27 meetings between BCBSK and St. Joseph and St. Francis hospitals, Wesley's primary competitors, prior to BCBSK's announced termination of Wesley as a contracting provider on August 29, 1985. Defendant contends the majority of those meetings concerned only the possible joint venture between the hospitals and BCBSK on the Kansas Health Plan HMO.

The deposition testimony of Marlon Dauner, BCBSK's Senior Vice President for External Affairs, was that the Steering Committee decided on August 12, 1985, *to recommend* to the Executive Committee of the Board of Directors that Wesley's contracting provider agreement be terminated at the end of the year. The committee decided at that same meeting to seek a reduction in the maximum allowable payments in the contracting provider agreements with the other Wichita hospitals. At a meeting the following day, August 13, between representatives of BCBSK, St. Joseph and St. Francis, Dauner specifically informed them the Steering Committee was going to recommend Wesley's termination. If implemented, he said, BCBSK would have a different insurance product in the Sedgwick County market, and was seeking the hospitals' acceptance of reduced MAPs for calendar year 1986. He told them he anticipated a discount of 15-20% was the amount necessary to secure a competitively priced product. By his own admission the hospitals were "concerned" about the reduced MAPs and asked what effect

Wesley's termination would have on their patient volume. Dauner responded "we have no *guarantee* that there would be any shift in patient volume" benefiting those hospitals at the expense of Wesley. Negotiations on the reduced MAPs continued throughout August and September, 1985. Prior to the decision to recommend the BCBSK Executive Committee terminate Wesley, in July defendant had sent to all contracting providers in Wichita, including Wesley, a proposed contract for calendar year 1986 contemplating a 4% *increase* in MAPs.

Although St. Joseph and St. Francis may not have agreed to the reduced MAPs by August 29, 1985, when the Executive Committee voted to terminate Wesley, neither had they unequivocally rejected them. It is clear from the record the Executive Committee was, at the time of its decision, aware of the ongoing negotiations and that the proposed reduction of MAPs was under consideration by the hospitals.

Evidence indicates the hospitals' concern about the 20% reduction. in MAPs was that BCBSK would be compensating them, at best, for simply their actual costs in providing services; they hoped to make up the difference by serving an increased volume of BCBSK subscribers. St. Joseph and St. Francis agreed to the reduced MAPs in September, 1985. The fact St. Joseph, with the tacit support of St. Francis, sought to delay implementation of the reduced MAPs following the litigants' voluntary agreement to continue abiding by the Wesley CAP

contract is not without significance.

BCBSK argues there is no evidence the agreement with those hospitals depended on defendant's termination of Wesley. But intent to conspire can be created by circumstantial evidence. The evidence defendant began its MAP negotiations with St. Francis and St. Joseph by announcing what was at that point the Steering Committee's mere *proposal* to terminate Wesley, the evidence those hospitals acquiesced in the reduced MAPs counting on a shift of patients (whether or not "guaranteed" by BCBSK), and the evidence certain members of the Executive Committee knew *for a fact* the hospitals would be "willing to accept a discount of some degree" when the Committee voted to terminate Wesley, creates a sufficient, if not significant, inference of unity of purpose, or common design and understanding, or meeting of the minds in an unlawful arrangement. Resolving this, and other inferences permissible from the evidence, in plaintiffs' favor, the Court declines to find the decision to terminate Wesley was purely unilateral on the part of BCBSK.

-Per Se vs. Rule of Reason Analyses-

Under the doctrine of per se illegality certain agreements or practices, because of their pernicious effect on competition and lack of any redeeming virtue, are conclusively presumed unreasonable and therefore illegal under Section 1 of the Sherman Act.

without elaborate inquiry into the precise harms they cause or the business reasons for their use. *White Motor Co. v. United States*, 372 U.S. 253 (1963); *Northern Pacific R. Co. v. United States*, 354 U.S. 1 (1958). By contrast, under the rule of reason the Section 1 reference to "restraint of trade" includes only acts, contracts, agreements or combinations which prejudice public interest by unduly restricting competition or unduly obstructing the course of trade, or which injuriously restrain trade because of their inherent nature or effect or because of their evident purpose. *Standard Oil Co. v. United States*, 221 U.S. 1 (1911); *United States v. American Tobacco Co.*, 221 U.S. 106 (1911). But per se rules are much looser in their condemnation than is often supposed; the rule of reason can be much more severe than is commonly assumed; and the categorization does not determine, and often obscures, what should be alleged, proved, or submitted to the jury. P. Areeda, The "Rule of Reason" in Antitrust Analysis: General Issues, pp. 25, 27 (Fed. Judicial Ctr. 1981).

Exactly what types of cases fall within the per se category is far from certain. The Supreme Court has stated that "judicial inexperience with a particular [market] arrangement counsels against extending the reach of the per se rules . . . ." *N.C.A.A. v. Bd. of Regents*, 468 U.S. 85 (1984). But the duration and depth of judicial experience with the health care industry is sufficient to permit application of the per

se rule to particular devices, such as price fixing, division of markets, group boycotts and tying arrangements, the anticompetitive effects of which have been long recognized. *Wilk v. AMA*, 719 F.2d 207 (7th Cir. 1983), *cert. denied* 467 U.S. 1210 (1984).

In its summary judgment motion defendant BCBSK argues there are no per se antitrust violations because there is neither evidence of price fixing nor a boycott. Defendant makes much of the fact that any agreement found in this case is vertical. But "[w]hether horizontal or vertical, the question is always one of competitive effects and redeeming virtues. The horizontal - vertical distinction is relevant only insofar as it bears on the assessment of competitive evils or justifications." Areeda, The "Rule of Reason," at 17.

Plaintiffs make no claim of price fixing in this case, and defendant argues none could possibly be made, relying on *Kartell v. Blue Shield of Massachusetts, Inc.*, 749 F.2d 922 (1st Cir. 1984), *cert. denied* 851 L.Ed.2d 322, 105 S.Ct. 2040 (1985). *Kartell* held Blue Shield's ban on balance billing, prohibiting doctors from making additional charges to Blue Cross subscribers, violated neither Section 1 nor Section 2 of the Sherman Act.

> We disagree with the district court's finding of "restraint." To find an unlawful restraint, one would have to look at Blue

> Shield as if it were a "third force," intervening in the marketplace in a manner tha prevents willing buyers and sellers from independently coming together to strike price/quality bargains. Antitrust law typically frowns upon behavior that impedes the striking of such independent bargains. The persuasive power of the district court's analysis disappears, however, once one looks at Blue Shield, not as an inhibitory "third force," but as itself the purchaser of the doctors' services. *See Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 214, 99 S.Ct. 1067, 1075, 59 L.Ed.2d 261 (1979) (direct reimbursement to participating pharmacies for subscribers' drugs "merely [an] arrangement[] for the purchase of goods and services by Blue Shield"). Antitrust law rarely stops the buyer of a service from trying to determine the price or characteristics of the product that will be sold. Thus, the more closely Blue Shield's activities resemble, in essence, those of a purchaser, the less likely that they are unlawful.

749 F.2d at 924-25.

We note with interest the Supreme Court's observation in *Royal Drug Co.*, a case relied on by the *Kartell* court:

> [E]xempting provider agreements from the antitrust laws would be likely in at least some cases to have serious anticompetitive consequences. Recent studies have concluded that physicians and other health-care providers typically dominate the boards of directors of Blue Shield plans. Thus, there is little incentive on the part of Blue Shield to minimize costs, since it is in the interest of the providers to set fee schedules at the highest possible level. This domination of Blue Shield by providers is said to have resulted in rapid escalation of health-care costs to the detriment of consumers generally. See Skyrocketing Health Care Costs· The Role of Blue Shield, Hearings before the Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce, 95th Cong. 2d Sess. 4-34 (1978) (remarks of Michael Pertschuk, Chairman, Federal Trade Commission).

440 U.S. at 232 n. 33.

Kartell's recognition of Blue Shield as a "customer" purchasing services from providers is not new. But that principle has not precluded findings of per se price fixing violations by BCBS plans in other cases involving different facts. *See Glen Eden Hospital v. BCBS of Michigan*, 740 F.2d 423 (6th

Cir. 1984) (if plaintiff for-profit hospital establishes collaboration between participating hospitals and BCBS on decisions to terminate plaintiff's contract, and setting more restrictive reimbursement levels for plaintiff, subject to a per se analysis); and *St. Bernard General Hospital v. Hosp. Service Ass'n*, 712 F2d 978 (5th Cir. 1983), *cert. denied* 467 U.S. 1210 (1984) (plaintiff established a prima facie showing of a per se price fixing violation by Blue Cross). This issue need not be pursued further because plaintiffs in this case have not claimed an illegal price-fixing arrangement by BCBSK. We do, however, emphatically reject defendant's argument such claims can never lie against a BCBS plan merely because of the role it plays in the health care market.

Count I of the complaint in this case alleges in part BCBSK's refusal to deal with Wesley. Cases in which the Supreme Court has applied the per se approach generally involved joint efforts by a firm or firms to disadvantage competitors by either directly denying or persuading or coercing suppliers or customers to deny relationships the competitors need in the competitive struggle. *Northwest Stationers v. Pacific Stationery*, 472 U.S. __, 86 L.Ed.2d 202, 211, 105 S.Ct. 2613 (1985). A concerted refusal to deal may merit per se treatment. *Northwest Stationers*, 86 L.Ed.2d at 212.

In *St. Bernard General Hosp. v. Hosp. Service Ass'n*, 712 F.2d 978 (5th Cir. 1983), *cert. denied* 466

U.S. 970 (1984), the court held plaintiff for-profit hospital had shown the prima facie effects of antitrust behavior in defendant Blue Cross' refusal to deal with the hospital.

> Whether a refusal to deal is a per se violation of the Sherman Act or subject to the rule of reason is not always a simple inquiry. Some cases claim that concerted refusals to deal always fall under the per se category. *E.g., Klor's, Inc. v. Broadway-Hale Stores Inc.,* [359 U.S. 207 (1959)]. Other cases, however, clarify the legal analysis and teach that certain factors must be present for a per se analysis to apply. There must be an anticompetitive motive behind the primary purpose of the agreement. *Joseph E. Seagram & Sons, Inc. v. Hawaiian Oke & Liquors, Ltd.*, 416 F.2d 71 (9th Cir. 1969), *cert. denied*, 396 U.S. 1062, 90 S.Ct. 752, 24 L.Ed.2d 755 (1970). There must be a commercial purpose to the agreement, rather than, for example, an attempt at industry self-regulation. *United States v. United States Trotting Assn.*, 1960 Trade Cases (CCH) ¶69,761 (S.D. Ohio 1960). *See also United States v. Insurance Board of Cleveland*, 144 F.Supp. 684 (N.D. Ohio 1956) (rules of county association of independent insurance agents subject to rule

> of reason under group boycott charges). The per se category also requires coercive economic pressure. *Klor's, Inc. v. Broadway-Hale Stores, Inc., supra*; *United States v. New Orleans Insurance Exchange*, 148 F.Supp. 915 (E.D. La.) (J. Skelly Wright, J.), *aff'd* 355 U.S. 22, 78 S.Ct. 96, 2 L.Ed.2d 66 (1957) (per curiam).

St. Bernard, 712 F.2d at 987-88. The court determined there need not be "hard evidence" of anticompetitive motive for a refusal to deal to merit per se treatment; "the law does not require a 'smoking gun' to prove concerted antitrust activity." *Id.*, at 988. Noting it was clear there was competition between plaintiff and the other hospitals contracting with BCBS, the court concluded:

> As to the district court's holding that any refusal to deal equally was reasonable, we notice that the prima facie effects of antitrust behavior have been shown. The only readily-apparent escape would be an affirmative defense that the restrictions were reasonable, or were the least restrictive methods to achieve a legitimate business goal. We cannot make such a finding until the defendant presents its case. *Even that evidence, were it to be presented, would of course not counter a per se violation.*

Id. (emphasis added).

The vertical agreements undertaken by BCBSK with the other Wichita hospitals in this case mirror those found in *St. Bernard*. These agreements were not attempts at industry self-regulation; indeed, consistent with defendant's repeated characterization of its role as a "customer" in the market, the agreements were clearly commercial in nature. Even though the Court need not find a "'smoking gun'" to prove concerted antitrust activity, there is in this case evidence of anticompetitive motive in the termination of, and refusal to deal with, Wesley. When the BCBS Executive Committee met on August 29 to consider action against Wesley, the question they voted on was *not* "how can we continue to serve our cost containment function in light of the developments in the Wichita market?" Significantly, the question posed was "do we want to continue to do business with our *competitors*?" There is evidence the committee voted "no" to that question knowing its action would hurt *both* Wesley and BCBSK itself, at least for the short term. There is also evidence of coercive economic pressure by BCBSK, not only from the *in terrorem* effect of the termination on other hospitals, but as well from defendant's express statements in an open letter to the members of the Kansas Hospital Association, dated October 4, 1985, from BCBSK's president, Wayne Johnston:

Regarding our future relationship with Kansas hospitals, I would emphasize that we wish to continue our long and satisfactory relationship with each hospital. We do believe that to properly serve our subscribers, we must make available highly desirable health benefit products at reasonable and competitive prices. We cannot stand idly by and watch insurance-hospital corporations, such as HCA, monopolize the delivery and financing of care by seeking to enroll Blue Cross and Blue Shield subscribers in their insurance programs. Vertical integration is a strategy some hospitals may feel to be in their best interest. *However, if hospitals decide to compete with Blue Cross and Blue Shield in the manner that HCA is competing, Blue Cross and Blue Shield must make a business decision about its future relationship with these entities. Hospitals that wish to continue their current relationship with Blue Cross and Blue Shield, that abide by the terms of our hospital agreement, that do not seek to enroll subscribers in other programs, and that wish to cooperate with Blue Cross and Blue Shield as a major marketing arm of the hospital, will experience no change in the contractual relationship that has*

historically served Kansans well.

(Emphasis added.) Even more pointedly, Marlon Dauner testified at deposition: "If [St. Joseph and St. Francis] accepted the [reduced] maximums, they would continue to be contracting hospitals with Blue Cross and Blue Shield and the benefits that go along with that." (Dauner Depo., pp. 157-58.)

This evidence alone establishes the prima facie effects of antitrust behavior, and under *St. Bernard* and the authorities that case relies on, very possibly a per se violation of Section 1.

BCBSK next argues Wesley's termination does not support plaintiffs' boycott allegations in Count II under a per se analysis. Defendant argues, first, there can be no per se boycott violation in this case because such a violation requires concerted attempts by a group of competitors at *one* level to protect themselves from competition. Here, by contrast, defendant points to the fact any agreement to be found in the evidence is of a *vertical* nature, between BCBSK as a customer and the other Wichita hospitals as suppliers. Second, defendant argues, even if there is evidence of a boycott, its legality must be tested under the rule of reason rather than a per se analysis.

In *Northwest Stationers v. Pacific Stationery*, the Supreme Court stated boycott cases to which the per se analysis properly applies are those in which. . . the boycott . . . cuts off access to a supply, facility,

or market necessary to enable the boycotted firm to compete, . . . and frequently the boycotting firms possess[] a dominant position in the relevant market. . . . In addition, the practices [are] generally not justified by plausible arguments that they were intended to enhance overall efficiency and make markets more competitive. Under such circumstances the likelihood of anticompetitive effects is clear and the possibility of countervailing precompetitive effects is remote.
86 L.Ed.2d at 211 (citations omitted).

Olsen v. Progressive Music Supply, Inc., 703 F.2d 432 (10th Cir. 1983), *cert. denied* 464 U.S. 866, answers most of defendant's arguments in this case. *Olsen* involved a Section 1 claim against a product distributor. Among the allegations was that defendant engaged in a group boycott of plaintiff retailer, in combination with the product manufacturers; a vertical arrangement, as is present in this case. Defendant Progressive argued, as does BCBSK here, that the group boycott should not be treated as a per se violation because it was "'at least potentially reasonably ancillary to joint, efficiency creating economic activities.'" *Id.* at 438, *quoting U.S. v. Realty Multi-List, Inc.*, 629 F.2d 1351, 1357 (5th Cir. 1980). The Tenth Circuit rejected that argument.

In this case there is evidence that there

was a boycott which was "clearly exclusionary or coercive in nature." *Gould v. Control Laser Corp.*, 462 F.Supp. 685, 691 (M.D. Fla. 1978), *aff'd*, 650 F.2d 617 (1981). Thus, the case differs from those in which "courts have circumvented the rigidity of the *per se* rule by reasoning that the need for its application 'depends not upon a finding that * * * [a restraint] constitutes a "boycott" but upon an analysis of its purpose and competitive impact.'" Note, The Facial Unreasonableness Theory: Filling the Void Between Per Se and Rule of Reason, 55 St. John's L.Rev. 729, 750 n. 155 (1981) (quoting *Gould*, *supra*, at 691). Procompetitive impacts or motives within the trial court's findings are difficult to see. For instance, Herger [the distributor] boycotted Olsen because "she had an independent prejudice against giving competitive dealers large discounts." In addition, Progressive harbored a "predatory intent toward competing dealers."

From the findings it would appear that the boycott engaged in by Progressive was *per se* violative of the antitrust laws. *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207, 79 S.Ct. 705, 3 L.Ed.2d 741 (1959) (*per se* violation of Sherman Act exists when department store conspires with appliance

> manufacturers and distributors to prevent sales to small retail appliance stores).

703 F.2d at 438-39.

In *Wilk v. AMA*, 719 F.2d 207 (7th Cir. 1983), *cert. denied* 467 U.S. 1210 (1984), among the plaintiff chiropractors' allegations under Section 1 was that defendant engaged in a group boycott by agreeing to induce individual doctors to forego any associations with the chiropractors, in the interests of quality patient care. The court said:

> On the theoretical side, the "boycott" which plaintiffs alleged and undertook to prove is surely not within any of the more familiar contexts. However, "[b]oycotts are not a unitary phenomenon." P. Areeda, *Antitrust Analysis* 381 (2d ed. 1974). "In its simplest aspects, a boycott . . . is nothing more than an agreement among a number of economic actors to sever or limit economic relations with another economic actor or actors." Bird, *Sherman Act Limitations on Non-commercial Concerted Refusals to Deal*, 1970 Duke L.J. 247, 248.
>
> Here, the jury was free to find that the services of one medical doctor were interchangeable with the services of other medical doctors; they competed with one another. The services of one chiropractor

were interchangeable with the services of other chiropractors; they competed with one another. The services of a relatively small number of medical doctors were interchangeable with the services of all or nearly all chiropractors; they competed with one another. *Superficially at least, the benefits to consumers arising from unrestrained competition could have been realized without any cooperation between any two medical doctors, between any two chiropractors, between any medical doctor and any chiropractor, or between an enclave of medical doctors and an enclave of chiropractors.*

* * *

What the antitrust law implications of all this may be for consumers of health care services, as distinguished from chiropractors as a group of health care providers, is difficult to discern.

* * *

It can fairly be said that the Supreme Court of the United States has been persistent and firm in its support of the *per se* doctrine. Since the trial of the case

before us, the Court has pointedly described and endorsed its virtues. *Arizona v. Maricopa County Medical Soc.*, 457 U.S. at 342-348, 102 S.Ct. at 2472-2475. Also, it is now firmly established that the members of learned professions and their professional associations are within the terms of Section 1 of the Sherman Act. *Id.* at 348-349, 102 S.Ct. at 2475-2476; *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 95 S.Ct. 2004, 44 L.Ed.2d 572 (1975). Nor are the duration and depth of the judiciary's experience with the health care industry too little to permit application of the *per se* rule to a particular device, such as price-fixing, the anti-competitive effects of which have long been recognized. *Arizona v. Maricopa County Medical Soc.*, 457 U.S. at 439-351, 102 S.Ct. at 2476-2477. Moreover, as recently as in *Arizona v. Maricopa County Medical Soc.*, a price-fixing case, the Court quoted approvingly this language from *Northern Pac. R. Co. v. United States*, 356 U.S. 1, 5, 78 S.Ct. 514, 518, 2 L.Ed.2d 545 (1958): "Among the practices which the courts have heretofore deemed to be unlawful in and of themselves are price fixing, division of markets, group boycotts, and tying arrangements." 457 U.S. at 344, n. 15, 102 S.Ct. at 2473 n. 15.

Id. at 218, 221 (emphasis added). The court noted that even a generalized public interest motive dominating the arrangement would not save it from a per se violation label if the conduct was such that label would otherwise clearly attach. *Id.* at 220-21. Nevertheless, the court concluded that on the particular facts of that case the per se rule would not apply to defendants' conduct first because of the patient care motive, and more importantly, because the coercion in the boycott alleged was *not* used "to compel either medical doctors or chiropractors to engage in certain economic behavior . . . [but] to engage in the boycott itself, and not to exert, through the boycott, compulsion on anyone to do or refrain from doing anything else." *Id.* at 221.

There is no doubt BCBSK plays a significant, if not dominant, role in the Kansas health care industry. In sharp contrast to the boycott in *Wilk*, the group boycott alleged in this case is not *among* members of the medical profession with bona fide concerns for patient care, but a boycott between an insurance company *with* members of that profession. *Olsen* held that vertical arrangements such as this are no less subject to per se treatment than horizontal arrangements. There is evidence BCBSK's agreements with St. Joseph, St. Francis and Riverside hospitals will reduce or eliminate access to those hospitals by HCP and other alternative delivery systems attempting to compete with BCBSK on equal terms. The boycott alleged is both exclusionary and

economically coercive. Enhanced market efficiencies, or procompetitive impacts and motives are difficult to discern. At no time did BCBSK claim it acted out of concern for the *quality* of patient care, one of the primary reasons the *Wilk* boycott was afforded treatment under the rule of reason. After BCBSK acted purely for "competitive" reasons, it argued to the public, and now this Court, its conduct was undertaken to ensure *low cost* medicare care. There is a significant question whether that was the true motive underlying defendant's conduct. But even assuming so, there is little if any indication from the evidence this "generalized public interest" necessitated defendant's actions. Low cost medical care benefiting consumers in the same manner might well have arisen from unrestrained competition, without the necessity of defendant's exclusionary and coercive conduct.

The Court concludes there is evidence in the record from which the jury could properly find conduct in the form of a concerted refusal to deal, and/or a group boycott, constituting per se violations of Section 1.

Defendant next argues its conduct is lawful under the rule of reason. The classic articulation of the rule of reason appears in *Chicago Board of Trade v. U.S.*, 246 U.S. 231, 238 (1918):

> The true test of legality is whether the restraint imposed is such as merely regulates

> and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation or the reverse; but because knowledge of intent may help the court to interpret facts and to predict consequences.

The inquiry mandated by the rule of reason is whether the challenged agreement is one that promotes competition or one that suppresses competition. *National Society of Professional Engineers v. United States*, 435 U.S. 679, 691 (1978).

It is the factfinder's responsibility to accept or reject a claim of per se antitrust violations. *Instructional Systems Development Corp. v. Aetna*, __ F.2d __, No. 82-2105, slip op. at 10 (10th Cir. Mar. 31, 1986). Given evidence from which a jury may find conduct constituting a per se violation, the jury may be instructed to decide whether a per se

antitrust violation has in fact occurred, or if not, to then apply the rule of reason to plaintiffs' Section 1 claims. *Wilk v. AMA*, 719 F.2d 207, 219 (7th Cir. 1983). In this case there is evidence and inferences from which the jury, as factfinder, can conclude per se violations occurred, and there is no reason for the Court at this stage to address the merits of plaintiffs' Section 1 claims under the rule of reason. The *Wilk* approach seems proper, and this case will go to the jury with alternate instructions on the per se and rule of reason analyses.

Defendant's motion for summary judgment on plaintiffs' Section 1 claims is denied.

Section 2 of the Sherman Act

Section 2 of the Sherman Act prohibits monopolization, attempts to monopolize, and combinations or conspiracies with other persons to monopolize any part of trade or commerce. Count IV of the complaint claims monopolization by BCBS; Count V claims an attempt to monopolize by BCBS; and Count VI claims defendant engaged in one or more conspiracies to monopolize.

-Monopoly-

"'The offense of monopoly under §2 . . . has two elements: (1) the possession of monopoly power in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from

growth or development as a consequence of a superior product, business acumen, or historical accident.'" *Aetna*, No. 82-2105, slip op. at 14 (10th Cir. Mar. 31, 1986), *citing U.S. v. Grinnell*, 384 U.S. 563, 570-71 (1966). Monopoly power is defined as the power to control prices in the relevant market and exclude competition. *Shoppin' Bag of Pueblo, Inc. v. Dillon Companies*, 783 F.2d 159 (10th Cir. 1986).

There is in this case much dispute over the size of the market share possessed by BCBSK. Its president, Wayne Johnston, and senior vice president, Marlon Dauner, testified in depositions that BCBSK holds insurance contracts with 37% of the Kansas population, though in its briefs defendant contends it is only 35%. Plaintiffs have evidence defendant accounts for 61% of earned health insurance premiums; defendant responds that is not the relevant market. The first problem with even the 37% figure is that represents the portion of the *total* Kansas population insured by BCBSK; it does not represent the percentage of defendant's market share among the portion of Kansas citizens who actually carry any health insurance, removing from consideration those who are self-insured. BCBSK responds such a figure is unavailable. But the Court notes that in other cases involving BC or BS plans, that relevant figure *has* been available and it has, logically, been higher than the percentage of the total population. *See Kartell v. Blue Shield*, 749

F.2d 922, 924 (1st Cir. 1984) (BS provides insurance to *56%* of Massachusetts population, but figure rises to *74%* after subtracting from total population those relying on government sponsored health care (Medicare, Medicaid)); *see also Ratino v. Medical Service of Dist. of Columbia*, 718 F.2d 1260, 1264 (4th Cir. 1983) (Blue Shield enrolls approximately 1.4 million D.C. residents in insurance plans; *80%* of all individuals *covered by health care insurance* in the area). The Court is comfortable assuming BCBSK's share of the *relevant* market is higher than 37%.

At oral argument defense counsel argued that even the 61% figure is insufficient to support plaintiffs' Section 2 monopolization claim, relying on *Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance, Inc.*, 784 F.2d 1325 (7th Cir. 1986). In that case the court found BCBS of Indiana lacked market power sufficient to support a monopolization claim.

> The district court found that each of the actors suggesting that market share does not imply market power is present in the market for medical insurance. New firms may enter easily. Existing firms may expand their sales quickly; the district court pointed out that insurers need only a license and capital, and that firms such as Aetna and Prudential have both. There are no barriers to entry--other firms may duplicate the Blues' product at the

same cost the Blues incur in furnishing their coverage. See George J. Stigler, *The Organization of Industry* 67-70 (1968) (defining barriers to entry as differentials in the long-term costs of production); cf. Harold Demsetz, *Barriers to Entry*, 72 Am.Econ.Rev. 47 (1982) (showing that not all barriers, as so defined, injure effective competition). The Blues and other nonprofits may have an edge because of the lower tax Indiana places on premiums paid to them, but this sort of advantage is not pertinent here. Other mutual insurance carriers (including Prudential) can get the same tax break. A PPO plan does not exploit the tax advantage as compared with any other plan the Blues could offer. The tax benefits may or may not be desirable as a matter of state policy, but this is no concern of antitrust law.

The Blues do not own any assets that block or delay entry. The insurance industry is not like the steel industry, in which a firm must take years to build a costly plant before having anything to sell. The "productive asset" of the insurance business is money, which may be supplied on a moment's notice, plus the ability to spread risk, which many firms possess and which has no geographic boundary. Cf. *Hood v. Tenneco Texas Life*

Insurance Co., 739 F.2d 1012, 1019 (5th Cir. 1984) (insurance industry marked by ease of entry); *Alabama Association of Insurance Agents v. Board of Governors*, 533 F.2d 224, 250-51 (5th Cir. 1976) (financial services in general are competitive because of the ease of moving money), modified, 558 F.2d 729 (1977), *cert. denied*, 435 U.S. 904, 98 S.Ct. 1448, 55 L.Ed.2d 494 (1978). The district court emphasized that every firm can expand its sales quickly if the price is right, that no firm has captive customers, and that many firms want to serve this market. The conclusion that the Blues face vigorous and effective competition is not clearly erroneous. See also *National Bancard Corp. v. VISA U.S.A., Inc.*, 779 F.2d 592, 604-05 (11th Cir. 1986) (defining a market of "all payment devices" on basis of a conclusion that one financial service is a ready substitute for another).

Still, the Hospitals say, the conclusion is legally irrelevant. Ease of entry and the absence of barriers do not matter if the defendant has a large market share. The Hospitals are wrong. Market share is just a way of estimating market power, which is the ultimate consideration. When there are better ways to estimate market power, the

court should use them. See *Waste Management, supra*. Market share reflects current sales, but today's sales do not always indicate power over sales and price tomorrow. . . .

* * *

The inquiry in each case is the ability to control output and prices, an ability that depends largely on the ability of other firms to increase their own output in response to a contraction by the defendants. Indeed it is usually best to derive market share *from* ability to exclude other sources of supply. This is the method the Department of Justice adopted in its Merger Guidelines. Cf. Landes & Posner, *supra*; George J. Stigler & Robert A. Sherwin, *The Extent of the Market*, 28 J.L. & Econ. 555 (1985). If the definition of the market builds in a conclusion that there are no significant additional sources of supply and no substitutes from the consumers' perspective, then the market share indicates power over price. But a calculation of the Blues' share of current coverage in Indiana does not capture the possibility of new entry and expanded sales by rivals, and this is why the district court properly held that the

> geographic market "is regional, if not national" This larger market may not seem useful from the perspective of consumers in Indiana, who must obtain their insurance from firms offering it there. It is highly pertinent, however, from the perspective of the Blues' rivals and potential rivals, and therefore from the perspective of constraints on the Blues' ability to raise price. The Blues' rivals, whose mobility is not restricted, protect consumers, whose mobility is restricted.
>
> The district court therefore did not commit a legal error or make a clear error in finding the facts. So far as the record stands, the Blues lack market power and are therefore entitled to adopt a PPO plan without further scrutiny under the Sherman Act.

Ball Memorial, 784 F.2d at 1335-37.

In *Board of Regents v. NCAA*, 707 F.2d 1147, 1159 (10th Cir. 1983), *aff'd* 468 U.S. 85 (1984), the court stated:

> In monopolization cases the court reaches for the degree of market power possessed by a firm with an extremely large market share. *See* 2 E. Kintner, *Federal Antitrust Law*

> §12.6 at 352, 356-57 (1980) (collecting cases and noting that the market share must approach 80% of the relevant market).

Plaintiffs point out this is dicta because the Tenth Circuit did not consider the plaintiffs' monopolization claim. *See* 707 F.2d at 1159 n. 16. They further explain the court's statement cannot be interpreted to mean monopoly power requires in all cases a showing of 80% market share. The discussion in the section of the Kintner work cited by the Tenth Circuit concerned cases in which monopoly power was inferred from market share alone. *See* 2 E. Kintner, *Federal Antitrust Law* §12.7 at 357 (1980). Kintner goes on to explain that in cases when a defendant's market share is less than the 80% figure, "monopoly power may [nevertheless] be inferred from the defendant's market position after consideration of the market share in relation to the characteristics of the relevant market." *Id.*, §12.5 at 351. Thus, Kintner concludes that where the defendant's market share exceeds a level of approximately 50%, "a detailed inquiry into other market characteristics is necessary" in assessing a monopolization claim. *Id.*, §12.7 at 358.

The Tenth Circuit's statement in NCAA must also be considered in light of the court's more recent comments in *Shoppin' Bag of Pueblo, Inc. v. Dillon Companies, Inc.*, 783 F.2d 159 (10th Cir. 1986). The court stated:

> It is generally agreed that while market share is indicative of market power, it is not the sole matter to be considered in assessing a defendant's market strength. Evaluating a firm's ability to achieve a monopoly by controlling prices and eliminating competition is a complex assessment based on as much information as is available to provide one with a broad understanding and appreciation of the market and competition in general. We believe that market power includes an examination of a defendant's market strength by analyzing many factors. [These factors are] largely dependent on the individual facts of any case . . . .

Shoppin' Bag, 783 F.2d at 162.

The Court is admittedly troubled with plaintiffs' monopolization claim. The *Ball Memorial* analysis certainly weighs in defendant's favor. There are factual distinctions between that case and the present one. In *Ball Memorial* BCBS of Indiana *kept* its traditional indemnity insurance plans on the market and simply attempted to introduce an *additional* PPO, making it available to *all* competing providers on a bid basis. It should be clear from our analysis of plaintiffs' Section 1 claims that BCBS Indiana's course of action was well advised. Of course, that distinction has little if any bearing on the question of

monopoly power under Section 2. Further, the Court recognizes the Tenth Circuit's remarks about market power in *Shoppin' Bag*, quoted above, regarded a Section 2 attempt to monopolize claim, and may be limited to that context.

Nevertheless the particular economic status of BCBS Indiana, as found in *Ball Memorial*, does not mean *ipso facto* all BCBS plans across the nation lack market power for purposes of a Section 2 monopolization claim. There is evidence BCBSK is significantly larger than its biggest competitor; the size and number of BCBSK's competitors are different than found in *Ball Memorial*; there is an overwhelming customer preference for BCBSK insurance plans in this state; and more. Plaintiffs have provided authorities affirming findings of monopoly power by defendants with greater than a 50% share of the relevant markets. *See, e.g., Syufy Enterprises v. American Multicinema, Inc.*, 783 F.2d 878 (9th Cir. 1986) (evidence was sufficient to support finding of monopolization where defendant had market share of 60-69% in highly fragmented market); *Pacific Coast Agricultural Export Ass'n v. Sunkist Growers, Inc.*, 526 F.2d 1196 (9th Cir. 1975), *cert. denied* 425 U.S. 959 (1976) (market shares ranging from 45-70% sufficient to constitute monopoly when other competitors small); *United States v. Besser Mfg. Co.*, 96 F.Supp. 304 (E.D. Mich. 1951), *aff'd* 343 U.S. 444 (1952) (65% market share sufficient for monopoly power where balance of

industry divided among 50 competitors the largest of which had market share of less than 8%).

The Court views plaintiffs' monopolization claim with some hesitation, but at this stage cannot conclude defendant has clearly shown it is entitled to summary judgment thereon. The present motion is denied with regard to the Section 2 monopolization claim. Plaintiffs will be allowed to present their evidence to the jury, but defendant is free to pursue its challenge to this claim at the close of that evidence.

-Attempt to Monopolize-

To support a claim of attempted monopolization under Section 2, plaintiffs must establish four items: (1) a dangerous probability of success; (2) acts in furtherance of the attempt, although these acts need not be successful; (3) specific intent to monopolize; and (4) a relevant market, within which the attempted monopolization occurred. *Shoppin' Bag*, 783 F.2d at 161; *Olsen v. Progressive Music Supply, Inc.*, 703 F.2d 432, 436-37 (10th Cir. 1983). Defendant argues plaintiffs fail to show either a dangerous probability of success in monopolizing the relevant market, or specific intent to monopolize.

The *Shoppin' Bag* case addressed in detail the element of dangerous probability of success. The court noted that traditionally, this element may be shown through the market power of the predatory defendant, which in turn may be shown through

market share. 783 F.2d at 161. The parties stipulated in that case to the relevant geographical market, and the relevant product market was the subject of a special interrogatory. The court continued:

> At the very least it must be shown how much of the relevant market a defendant controls if market power is to be evaluated. Of course, other conduct or circumstances may also be considered. *Olsen, supra*, at 437, (aggressive conduct of the plaintiff was considered in plaintiff's failure to establish that there was a dangerous probability that the defendant could monopolize the relevant market); and *U.S. Steel, supra*, (where the Supreme Court not only examined U.S. Steel's declining market percentage over a 45-year period but also noted the other companies and means of production that U.S. Steel had acquired during the period.) Many cases also look at market trends, number and strength of other competitors, and entry barriers.
>
> It is generally agreed that while market share is indicative of market power, it is not the sole matter to be considered in assessing a defendant's market strength. Evaluating a firm's ability to achieve a monopoly by controlling prices and eliminating competition is a complex assessment based on as much

information as is available to provide one with a broad understanding and appreciation of the market and competition in general. We believe that market power includes an examination of a defendant's market strength by analyzing many factors. Although largely dependent on the individual facts of any case, examples of factors to be considered can be found in the instructions given in this case as quoted below. The trial court here instructed the jury that:

> The second element you must consider in this case is whether there was a dangerous probability that King Soopers could succeed in monopolizing the relevant market. "Dangerous probability" means the probability of attaining the power to control prices in the market and the power to exclude competition from the market.
>
> The greater a firm's market power, the greater the possibility of successful monopolization.
>
> In order to be found liable for attempted monopolization, a firm must possess market strength--market strength that approaches

> monopoly power; that is, the ability to control prices and exclude competition.
>
> Market strength is often indicated by market share. Market share alone, however, is not enough to determine a firm's capacity to achieve monopoly.
>
> Other factors you should consider include the number and strength of the defendant's competitors, the difficulty or ease of entry into the market by new competitors, consumer sensitivity to change in prices, innovations or developments in the market, whether the defendant is a multimarket firm, as well as other evidence presented to you that you may deem persuasive regarding defendant's market strength.

Id. at 161-62. The Section 2 attempted monopolization claim against defendant in *Shoppin' Bag*, which held a *34-38%* share of the relevant market, was held properly submitted to the jury with the foregoing instructions. *Id.*, at 161, 163.

In this case BCBSK has indicated no substantial

objections to the 61% market share figure. In purely numerical terms that market share indicates almost twice the market strength of the defendant in *Shoppin' Bag*, with a correspondingly greater possibility of successful monopolization. But even disregarding defendant's increased market share in this case, *Shoppin' Bag* clearly indicates it is the factfinder's prerogative to hear the evidence, and weigh the factors identified, in determining a defendant's dangerous probability of success. Those factors are sufficiently satisfied in this case to create a question of fact for this jury.

The specific intent necessary to prove an attempt to monopolize is a specific intent to accomplish the forbidden objective, an intent going beyond the mere intent to do the act. *Aspen Skiing Co. v. Aspen Highlands Skiing*, 472 U.S. __, 86 L.Ed.2d 467, 480, 105 S.Ct. 2847 (1985). Specific intent may be inferred from predatory behavior:

> "'Proof of specific intent to engage in predation may be in the form of statements made by the officers or agents of the company, evidence that the conduct was used threateningly and did not continue when a rival capitulated, or evidence that the conduct was not related to any apparent efficiency.'"

Aspen Skiing, 86 L.Ed.2d at 484 n. 39, *quoting* R.

Bork, The Antitrust Paradox at 157 (1968). The court upheld a jury verdict on an unspecified Section 2 claim because the defendant, in refusing to continue a joint product market effort with its competition, "elected to make an important change in a pattern of distribution that originated in a competitive market and had persisted for several years," adversely affecting plaintiff, customers, and defendant itself; the court found the jury could well have concluded defendant was engaged in predatory behavior by attempting to exclude rivals on some basis other than efficiency. *Id.* at 481-86.

In light of *Aspen*, defendant BCBSK cannot plausibly argue its conduct in this case is incapable of being characterized as predatory, supporting an inference of specific intent to monopolize. BCBSK's termination of Wesley was an election to make an important change in the pattern of distribution of health care in Sedgwick County, a pattern that originated in a competitive market and persisted for several years. Both that termination and the contracts entered into with the remaining Wichita hospitals imposed costs on plaintiff Wesley, plaintiff HCP (defendant's rival), the other hospitals, BCBSK itself, and very possibly, consumers. This conduct was unmistakably "exclusionary", tending both to impair the opportunities of defendant's rivals, and either not furthering competition on the merits or doing so in an unnecessarily restrictive way. Wholly aside from the fair characterization of BCBSK's conduct as predatory, as previously discussed in our

Section 1 analysis, there remain significant questions of fact concerning the precise reasons defendant acted as it did. If the jury concludes defendant conducted itself in these matters for any reason other than legitimate business purposes, that conclusion would support an inference of specific intent without regard to the predatory nature of its conduct.

Defendant does not argue the other elements of an attempted monopolization claim (predicate acts and relevant market) have not been established plaintiffs. Accordingly, defendant is denied summary judgment on plaintiffs' claims of attempted monopolization in violation of Section 2.

-Conspiracy to Monopolize-

To establish a conspiracy to monopolize in violation of Section 2, plaintiffs must show an agreement, overt acts in furtherance of the agreement, and a specific intent to monopolize. *Instructional Systems Develop. Corp. v. Aetna Casualty*, __ F.2d __, No. 82-2105, slip op. at 11 (10th Cir. Mar. 31, 1986). The gravamen of the offense is the intent to achieve the unlawful result. *Id.* at 12. A relevant market need not be established because specific intent to monopolize is the heart of the charge. *Olsen*, 703 F.2d at 438.

From our prior analysis it is clear defendant is not entitled to summary judgment on plaintiffs' claim of conspiracy to monopolize. The Court determined

in the discussion of plaintiffs' Section 1 claims there is substantial evidence from which the jury can find an agreement between BCBSK and the other Wichita hospitals, which contemplated within its terms the termination of Wesley as a contracting provider. That termination by BCBSK certainly qualifies as an overt act in furtherance of the agreement. As discussed in the analysis of plaintiffs' claim of attempted monopolization, the jury may infer specific intent to monopolize from either, or both, the actual reasons underlying defendant's conduct or the predatory nature.

Defendant is denied summary judgment on plaintiffs' Section 2 claim of conspiracy to monopolize.

PLAINTIFFS' STATE LAW CLAIMS

Counts VII - XVII of the complaint contain plaintiffs' pendent state and common law claims. Count VII alleges an unlawful trust violating K.S.A. 50-101. Count VIII alleges a combination in restraint of trade and free competition in violation of K.S.A. 50-112. Count IX alleges a violation of K.S.A. 50-132 by a conspiracy or combination for the purpose of monopolizing. Plaintiffs claim in Count X defendant has engaged in a civil conspiracy, actionable in tort. Count XI alleges a violation of K.S.A. 40-19c *et seq.*, BCBSK's special enabling act. In Count XII plaintiffs claim the proposed termination of Wesley is void as contrary to public

policy and defendant's enabling act. Count XIII alleges breach of Wesley's contracting provider agreement. Count XVI alleges the nonassignment of benefits provision of BCBSK's insurance policies with subscribers is void and unenforceable. Counts XIV, XV and XVII contain various claims of tortious interference.

Defendant contends the premise of all seventeen pendent claims is that BCBSK is required by Kansas law to contract with, and accept assignment of subscribers' benefits to, any hospital agreeing to the terms of the provider agreements. It argues that premise is invalid in light of the Kansas Supreme Court's decisions in *Augusta Medical Complex, Inc. v. Blue Cross*, 227 Kan. 469, 608 P.2d 890 (1980) ("*Augusta* I"), and *Augusta Medical Complex, Inc. v. Blue Cross*, 230 Kan. 361, 634 P.2d 1123 (1981) ("*Augusta* II").

Defendant relies on *Augusta* I for the proposition BCBSK's termination of Wesley as a contracting provider would be neither a violation of defendant's enabling act nor a breach of contract. *Augusta* I concerned Blue Cross' attempt to switch from retrospective reimbursement arrangements with providers to mandatory prospective reimbursement contracts, a change in contract urged upon Blue Cross by the Kansas Insurance Commissioner. 227 Kan. at 471. The existing contracts of providers that did not voluntarily agree to the new prospective reimbursement contracts were terminated by Blue

Cross. Twenty-one hospitals filed a declaratory judgment action, seeking specific performance of the contracts and injunctive relief. *Id.*, at 470, 472. The trial court issued a temporary injunction, and Blue Cross appealed. *Id.* The Kansas Supreme Court held the injunction improperly issued because, under the terms of the contracts in question, Blue Cross possessed and properly exercised a clear right to terminate the hospitals without cause on six months notice. *Id.*, at 475. The court determined the contracts were neither illegal nor contrary to public policy. The parties specified a method of mutual termination, "and we see no reason why the right of termination at the will of either party should not be honored by the parties and enforced by this court . . . . When the right to terminate a contract is absolute under the clear wording in the agreement the motive of a party in terminating such an agreement is irrelevant to the question of whether the termination is effective." 227 Kan. at 476.

The critical factual distinctions between that case and the present are obvious. In *Augusta* I Blue Cross terminated the hospitals' contracting provider agreements in order to implement new contracts with different reimbursement formulas, indicating its desire all hospitals continue as participants under the new arrangement. In stark contrast, there is in this case no question of a hospital refusing to join BCBSK's efforts; defendant has terminated and is refusing to contract with Wesley, a willing hospital.

Nor is there any indication defendant's conduct was encouraged by the State Insurance Commissioner. In this context defendant's reliance on the Supreme Court's statement "motive . . . is irrelevant," is unpersuasive. Clearly, the court there considered both the purpose of the terminations and the public policy favoring health care cost containment. Read literally, *Augusta* I stands for the principle defendant may exercise its right of terminating contracting provider agreements when undertaken in furtherance of its legislative mandate. In the present case it remains to be shown defendant's termination of Wesley, without offering the hospital a new provider agreement, serves the same or other permissible goals. The question whether BCBSK has the power to terminate a willing hospital and arbitrarily exclude it from participating status was never presented to the court, much less ruled on, in *Augusta* I.

In *Augusta* II, the Kansas Supreme Court addressed the enforceability of Blue Cross' refusal to accept assignment of subscribers' benefits to noncontracting hospitals. Following the termination of the hospitals as contracting providers in *Augusta* I, a number of those hospitals refused to participate in Blue Cross' new prospective reimbursement contracts. They instituted a declaratory judgment action to determine whether the nonassignment provision of subscribers' contracts was enforceable. *Augusta* II, 230 Kan. at 361-62. The court first reviewed the law and public policy supporting free

assignment of choses in action. Although recognizing the desirability of free alienation of choses in action, the court stated that principle was subject to other competing considerations of public policy. *Id.*, at 363-64. After reviewing Blue Cross' enabling act the court found "Blue Cross has a clear legislative mandate to control costs in ~~member~~ hospitals. Inherent in that dictate is a directive to encourage hospitals to become members." *Id.*, at 365. K.S.A. 40-1811(c) specifically provides Blue Cross' efforts "shall include . . . a continuing effort . . . through a combination of education, persuasion and financial incentives and disincentives to contr~~ol co~~sts and to encourage participating hospitals to control costs . . . ." The court concluded:

> [T]he provision in the subscribers' contracts rendering benefits personal and nonassignable is vital to the functioning of defendant Blue Cross as a mutual nonprofit hospital service corporation in carrying out its statutory duties and obligations and, accordingly, public policy requires that the same be upheld as valid and enforceable.

230 Kan. at 367. *See also Obstetricians-Gynecologists, P.C. v. Blue Cross and Blue Shield of Nebraska*, 219 Neb. 199, 361 N.W.2d 550 (1985) (the nonassignment of benefits clause is "a valuable tool in persuading health care providers to participate . . . in voluntary cost-effectiveness

programs and accept set fees for health services, keeping health care costs down and passing savings on to subscribers"; a far stronger public policy than that of free alienability of choses in action); and *Kent General Hospital, Inc. v. Blue Cross and Blue Shield of Delaware, Inc.*, 442 A.2d 1368 (Del. 1982) (following *Augusta* II but recognizing the holding as an exception to general rule of free alienability of choses in action).

The factual distinctions between the present case and *Augusta* II are, again, obvious. The sole reason the court in *Augusta* II permitted enforcement of Blue Cross' nonassignment of benefits provision was that Blue Cross needed that financial disincentive to *encourage* hospitals to become participating providers subject "to the restrictions and controls indigenous to membership." 230 Kan. at 366. In this case BCBSK has undertaken the unilateral termination of a hospital willing to continue as a participating provider. Defendant cannot argue its nonassignment of benefits policy is intended under these circumstances to serve the statutory purposes relied on by the court in *Augusta* II.

In this distinction defendant has removed itself from the *Augusta* II exception to the well-established policy favoring free alienability of choses in action. BCBSK puts forth no new or different justifications for refusing to honor assignment of subscribers' benefits to hospitals it has unilaterally terminated from participating status; defendant

simply contends *Augusta* II permits defendant to refuse to honor assignment of benefits under any circumstances. It does not.

Any lingering doubts on this issue are dispelled by the Second Restatement of Contracts. "A contractual right can be assigned unless . . . (c) the assignment is validly precluded by contract." Restatement (Second) of Contracts §317(2) (1981). But "[i]f there is no forfeiture [provision that an attempt to assign forfeits the right to payment of money], and the obligee joins in demanding payment to the assignee, a contractual prohibition which serves no legitimate interest of the obligor is disregarded." *Id.*, §322, Comment b.

Augusta I and II provide defendant no relief from plaintiffs, pendent state claims in this case. Failing to establish the legality of Wesley's termination as a contracting provider, and BCBSK's refusal to honor assignment of benefits, defendant is denied summary judgment on Counts VII - XVII of the complaint.

MOTION FOR RECONSIDERATION OF SEPARATE TRIALS

In the order dated January 8, 1986 adding HMOK as a counter-claim plaintiff and HCA as a counterclaim defendant, the Court also granted plaintiffs' motion for separate trials of the complaint and the counterclaim, with leave granted defendant to seek reconsideration of that ruling following discovery. (Rec. 24.) BCBSK and HMOK now seek reconsideration of the ruling on separate trials, and raised the matter before the Court during oral argument on the motion for summary judgment, at which time it was taken under advisement. Now armed with something more than a passing familiarity with the facts of this case, the Court is convinced separate trials on the complaint and counterclaim are justified. The order of separate trials is affirmed, and defendant's motion for reconsideration of that ruling is denied.

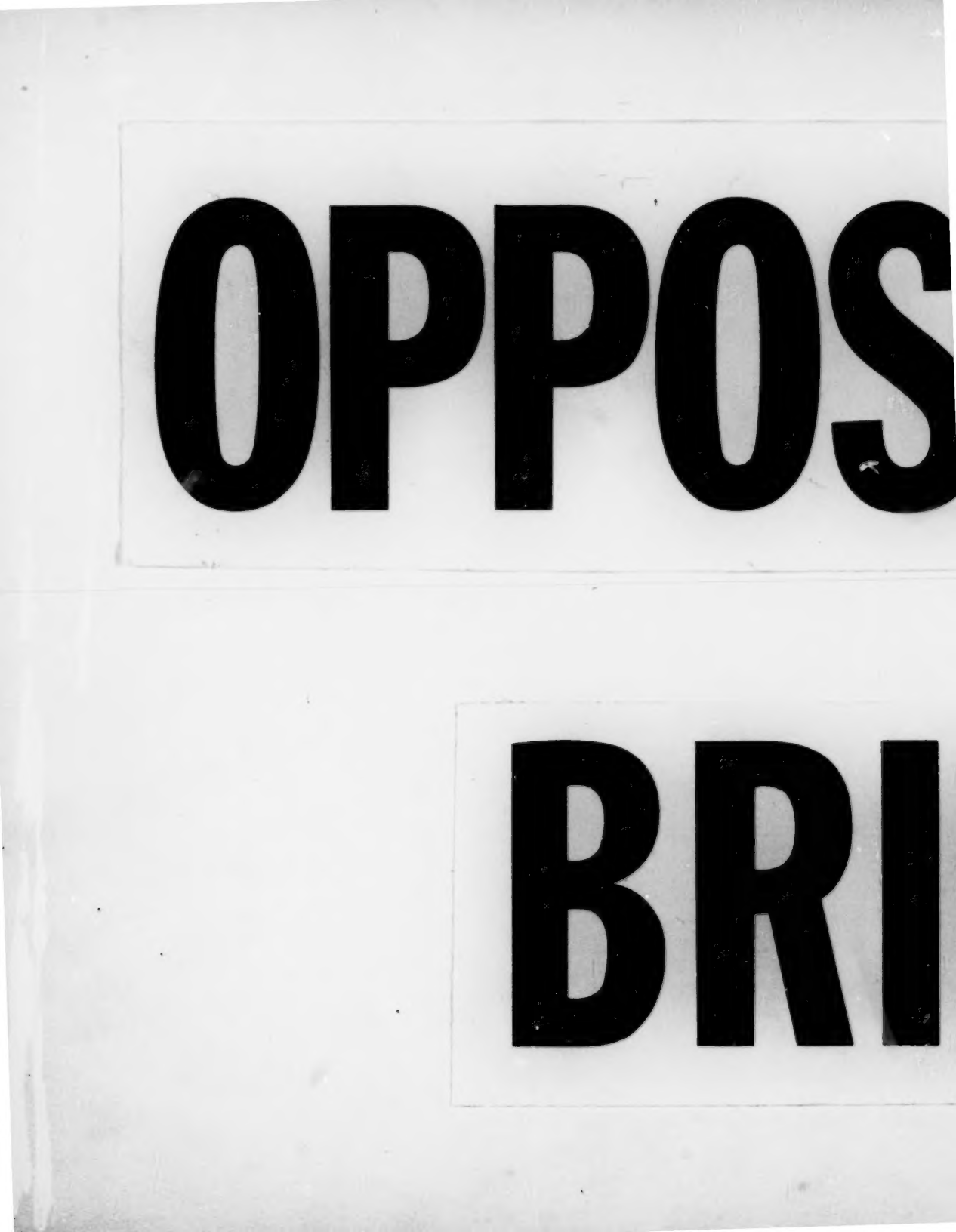
IT IS ACCORDINGLY ORDERED this 23 day of May, 1986 defendant Blue Cross and Blue Shield of Kansas, Inc. is granted summary judgment on the claims of plaintiffs Walter L. Reazin, M.D., and New Century Life Insurance Co., under Section 4 of the Clayton Act, 15 U.S.C. §15. Defendant's motion for summary judgment is in all other aspects denied.

IT IS FURTHER ORDERED the motion of Blue Cross and Blue Shield of Kansas, Inc., and HMO Kansas, Inc., for reconsideration of the order

of separate trial on their counterclaim is denied.

Trial to the jury on plaintiffs' complaint will begin Tuesday, July 22, 1986, at 9:30 A.M. The parties shall file their suggested jury instructions on or before Friday, July 18, 1986. Counsel for all parties shall report to Court chambers on Monday, July 21, 1986, at 2:00 P.M. for a conference in anticipation of trial.

PATRICK F. KELLY, JUDGE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Supreme Court, U.S.
MAY 29 1990

No. 89-1839

IN THE

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OCTOBER TERM, 1989

BLUE CROSS AND BLUE SHIELD OF KANSAS, INC. and HMO KANSAS, INC.,

Petitioners,

v.

WALTER L. REAZIN, M.D.; HCA HEALTH SERVICES OF KANSAS, INC., d/b/a/ Wesley Medical Center; HEALTH CARE PLUS, INC.; and NEW CENTURY LIFE INSURANCE CO.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

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BRIEF IN OPPOSITION

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QUESTION PRESENTED

Petitioners entered into an agreement with two Wichita hospitals to boycott the leading hospital in that city, Wesley Medical Center ("Wesley"), because it had been acquired by the parent of a competing insurance carrier; the purpose of that agreement was to injure the competing carrier and Wesley and to send a message to other hospitals not to deal with competing insurance carriers. The question presented is whether these activities violate Sections 1 and 2 of the Sherman Act and result in antitrust injury.

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BRIEF IN OPPOSITION

Respondents respectfully request that this Court deny the petition for a writ of certiorari filed on May 24, 1990, to review the judgment of the United States Court of Appeals for the Tenth Circuit entered in this proceeding on March 29, 1990.[1]

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[1] Pursuant to Rule 29.1, the parent corporations of HCA Health Services of Kansas, Inc., are: HCA—Hospital Corporation of America; its wholly-owned subsidiary, Hospital Corporation of

STATEMENT

From the perspective of this Court, this case is simple and straightforward. Petitioner Blue Cross and Blue Shield of Kansas, Inc. ("Blue Cross") is the largest private health care financing organization in Kansas. (Pet. App. at 8b.) In 1985, the Hospital Corporation of America ("HCA") entered the health care financing business in Wichita, Kansas, when it acquired the Wesley Medical Center ("Wesley") and Health Care Plus, a health maintenance organization. Blue Cross responded by threatening to terminate Wesley's "contracting provider agreement" [2] with Blue Cross in conspiracy with two compet-

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America; and its wholly-owned subsidiary, HCA, Inc. HCA Health Services of Kansas, Inc. has sister corporations that operate hospitals in other states. The only publicly traded securities are the debt and preferred shares of HCA—Hospital Corporation of America.

[2] In an "all provider" indemnity insurance program, like that created by Blue Cross' contracting provider agreement, the insurance carrier reimburses a subscribing consumer for all of his costs at any *contracting* provider of his choice. *See* Pet. App. at 6c. Blue Cross threatened to terminate Wesley's contracting provider status, which would have made Wesley the *only* hospital in the Blue Cross service area not to enjoy that status. *Id.*

The trial court described the importance to a hospital of having a Blue Cross contracting provider agreement and the disadvantages of non-contracting status. Pet. App. at 7d-10d. The Tenth Circuit described how Blue Cross intended to affect consumers (subscribers) and thus to injure Wesley by cancelling that agreement:

> [S]ubscribers using Wesley (1) would not have the same assurance of predictability of health care costs which the maximum allowable payment concept guarantees; (2) would not get the benefit of the 'hold harmless' clause limiting their liability; and (3) would not have access to direct payment of claims from Blue Cross to the hospital.

Pet. App. at 12b-13b n.7. Accordingly, Blue Cross intended to instigate a significant shift of Blue Cross patients from Wesley to the Saints as a consequence of the termination, and advertised in the media to encourage that shift. *See* Pet. App. at 44d.

ing hospitals. (Those hospitals are referred to collectively as "the Saints.") (Pet. App. at 20b.)

This scheme was specifically intended to deter competition with Blue Cross by harming Wesley and thus sending a message to all other Kansas hospitals. The message was simple: Blue Cross will punish any hospital that does business with a competitor of Blue Cross, just as it punished Wesley, the largest hospital in the state. *See* Pet. App. at 11b-17b & 33b-38b. And the message was unmistakable. Blue Cross sent it in a contemporaneous letter from Blue Cross' President to all Kansas hospitals:

> . . . [I]f hospitals decide to compete with Blue Cross and Blue Shield in the manner that [Wesley] is competing, Blue Cross and Blue Shield must make a business decision about its future relationship with these entities. Hospitals that wish to continue their current relationship with Blue Cross and Blue Shield, that do not seek to enroll subscribers in other programs, and that wish to cooperate with Blue Cross and Blue Shield as a major marketing arm of the hospital, will experience no change in the contractual relationship that has historically served Kansans well. (Pet. App. at 15b n.8).

Thus, Blue Cross did not simply establish a vertical prefered provider organization ("PPO") with the Saints.[3]

After a six-week trial, a unanimous jury found that Blue Cross had damaged Wesley by engaging in predatory conduct in violation of both the Sherman Act and Kansas state law. The trial court denied Blue Cross' numerous post-trial motions. *See* Pet. App. at 1c-377c. On appeal, the Tenth Circuit affirmed. Its opinion was unanimous; it was lengthy; and it was carefully reasoned.

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[3] In a PPO, a subscribing consumer's health care costs are fully reimbursed if he uses an approved doctor or hospital, but only partially reimbursed if he uses a non-approved provider.

In affirming the jury's findings of a violation of Section 1 and Section 2 of the Sherman Act, the Tenth Circuit found sufficient evidence of Blue Cross' willful acquisition or maintenance of monopoly power:

> We have little difficulty concluding that Blue Cross' total conduct in this case—threatening to terminate Wesley's contracting provider agreement and reducing the maximum allowable payments for the remaining Peer Group V hospitals, thereby coercing other hospitals into not doing business with Blue Cross competitors—constituted willful maintenance of its monopoly power. A general intent to do so is amply supported by the record.

Pet. App. at 58b. The Tenth Circuit concluded that the proven injuries to Wesley (*see* Pet. App. at 54b-56b) were thus an integral—indeed, a necessary—part of the message sent to all Kansas hospitals.

Thus, as both the district court and the Tenth Circuit recognized, the antitrust violation here was not the creation of a PPO, but rather Blue Cross' predatory effort to exclude HMO's, PPO's, and other managed care competition by punishing Wesley for becoming part of an integrated enterprise, and thus to deter other hospitals from entering similar relationships with Blue Cross' competitors. Pet. App. at 37b & 120c. The jury found a violation of the antitrust laws, and the Tenth Circuit affirmed. On May 16, 1990, petitioners moved the Tenth Circuit to reconsider its decision in light of this Court's decision in *Atlantic Richfield Co. v. USA Petroleum Co.*, 58 U.S.L.W. 4547 (May 14, 1990). On May 22, 1990, the Tenth Circuit denied petitioners' motions.

ARGUMENT

Blue Cross raises no issue of national importance, or split within the circuits, that would justify further reviewing the well-reasoned decision below.

I. THE TENTH CIRCUIT FOLLOWED THIS COURT'S PRECEDENTS IN FINDING ANTITRUST INJURY.

Petitioners argue that the Tenth Circuit incorrectly analyzed whether Wesley suffered antitrust injury as a consequence of Blue Cross' threatened boycott of Wesley. They argue that the Tenth Circuit's decision is inconsistent with this Court's decision in *Atlantic Richfield Co. v. USA Petroleum Co.*, 58 U.S.L.W. 4547 (May 14, 1990) (hereinafter "*ARCO*"), and the older decisions in *Brunswick* and *Cargill*. But the Tenth Circuit carefully followed *Brunswick* and *Cargill* (Pet. App. at 21b-28b), and *ARCO* merely reaffirms the Tenth Circuit's conclusion (*see* Pet. App. at 25b n.15) that "[a]n injury which is merely causally linked in some way to an alleged antitrust violation is insufficient" to establish antitrust injury. *ARCO*, 58 U.S.L.W. at 4549. *ARCO* confirms existing precedent and provides no basis for a different conclusion in this case. Indeed, on May 16, 1990, petitioners moved the Tenth Circuit to reconsider its decision in light of *ARCO*. On May 22, 1990, the Tenth Circuit denied petitioners' motions.[4]

ARCO is a simple vertical pricing case. There, the plaintiff could *only* have been injured by the alleged vio-

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[4] The argument that Wesley lacked standing because it did not suffer antitrust injury was also waived: "Throughout this litigation, defendant has never challenged Wesley's standing under § 1, and it may not do so now." Pet. App. at 160c. On appeal, the Tenth Circuit again recognized that petitioners probably waived any objection to standing, but opted nonetheless to address the standing issue to put the issue to rest. (Pet. App. at 22b-24b & n.13.) This Court should not grant certiorari to resolve an issue that was waived below.

lation if the violation *increased* competition; any other result of the alleged violation would have worked to the benefit of the plaintiff. *ARCO*, 58 U.S.L.W. at 4549. As has been clear from at least *Brunswick*, "[i]t is inimical to [the antitrust] laws to award damages for losses stemming from continued competition." *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977). By contrast, as the Tenth Circuit noted in its opinion, "Wesley's claimed injuries were an 'integral aspect' of the conspiracy to restrain trade. . . . Indeed, Wesley was the direct victim of Blue Cross' actions." Pet. App. at 28b.

This was a much more complex conspiracy than that involved in *ARCO*. It had both vertical and horizontal elements, involving Blue Cross' conspiracy with Wesley's hospital competitors to injure Wesley and thereby deter other hospitals from entering relationships with competitors of Blue Cross in health care financing. As the Tenth Circuit observed, "this case does not involve only, as defendants argue, the termination of a vertical relationship, akin to a dealer termination. Rather, this case also involves a horizontal conspiracy among competitors to harm another competitor." (Pet. App. at 36b.)

Here, Blue Cross set out to protect its dominant position in the health care financing market by enlisting the support of Wesley's hospital competitors in a conspiracy to boycott Wesley. Blue Cross designed the boycott to raise Wesley's costs and deter competition (by Wesley's parent, HCA and others) in health care financing through intimidating hospitals from entering into relationships with Blue Cross' competitors. While Blue Cross' long-term goals were frustrated by this litigation, its short-term objective was successful; Wesley's costs were in fact raised. *See* Pet. App. at 25b-28b & 54b-56b. The resulting damages proven and awarded were not only causally linked to the antitrust violation claimed, but directly "flow from the aspects of [the violation] that ren-

der it illegal." *ARCO*, 58 U.S.L.W. at 4549. Indeed, without visible damage to Wesley, Blue Cross' ultimate anticompetitive objectives could not have been met.

This is not a case of unanticipated or coincidental injury. Nor is it a case (like *Brunswick* or *ARCO*) where a competitor seeks to recover damages because of increased competition. Blue Cross' conduct was neither procompetitive nor proconsumer, and the Tenth Circuit so found. (Pet. App. at 38b.) It was predatory conduct—an attempt to use existing market power and collusion to protect a dominant position and impose additional costs on rivals. Petitioners intended to blunt the competitive potential of those rivals and, if not prevented by this litigation, their efforts would have had significant anticompetitive effects. *See* Pet. App. at 37b-39b. To the extent that the first phase of their plan did succeed (albeit only for a limited period in this case because of the unusual procedural facts recognized by the Tenth Circuit, *see* Pet. App. at 55b-56b), Wesley is entitled to recover the damages it suffered—damages that were not only caused by the illegal conduct, but that were its specific goal.

Unlike the plaintiff in *ARCO*, Wesley's proven damages are "inextricably intertwined" with Blue Cross' anticompetitive conduct. *Blue Shield of Virginia v. McCready*, 457 U.S. 465, 484 (1982); *ARCO*, 58 U.S.L.W. at 4551. They are properly recoverable, and there is no reason to grant certiorari.

II. THIS CASE CREATES NO CONFLICT AMONG THE CIRCUITS BECAUSE BLUE CROSS' ANTICOMPETITIVE CONDUCT, NOT THE LEGALITY OF PPO'S, IS THE ISSUE.

Petitioners next argue, as they did in the courts below, that the jury findings conflict with rulings of other circuit courts involving "vertical preferred provider arrangements involving health insurers." Pet. at 23. Peti-

tioners urge that this case ". . . subjects such arrangements [PPO's] to antitrust liability, disserves consumers of health care and penalizes competition." Pet. at 3. This not only exaggerates but twists the impact of this case. Far from simply establishing a PPO, Blue Cross' conduct was in fact intended to *deter* the introduction of HMO's, PPO's, and other innovative forms of health care delivery. *See* Pet. App. at 51b & 120c.

Petitioners also urge that the Tenth Circuit "expressly declined to follow the reasoning of the Seventh Circuit in *Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance*, 784 F.2d 1325 (7th Cir. 1986)." Pet. at 14. But the Tenth Circuit did not find *Ball Memorial* applicable and unpersuasive—which might create a circuit split. Rather, it found the case "distinguishable." Pet. App. at 53b n.32. Indeed, the trial court opined that the "factual distinctions between this case and *Ball Memorial* cannot be overemphasized."[5] Pet. App. 145c-147c & 362c n.16. *See also* Pet. App. at 108d-110d. No conflict exists between the Seventh and Tenth Circuits over questions of law.

The Tenth Circuit properly distinguished *Ball Memorial* and other pure PPO cases from the Blue Cross conduct at issue here. Unlike the cases in other circuits, this case did *not* involve a mere "vertical preferred provider arrangement." Rather than simply choosing which hospitals it wanted to do busines with, Blue Cross set out to discourage all hospitals in Kansas from doing business with any of its insurance competitors, especially Wesley's parent, HCA. Pet. App. at 146c & 362c-364c n.16. As the jury and trial court found, this "casts a disturbing light" on Blue Cross' "pious assertion this 'new PPO' operates to the unqualified benefit of Kansas consumers

[5] Perhaps the most obvious factual distinction is that the Seventh Circuit did not even view *Ball Memorial* as a case in which the defendant was attempting to eliminate or deter insurance competition. In this case, the jury found that was the primary objective of Blue Cross. Pet. App. at 146c & 362c n.16.

of health care financing products." Pet. App. at 146c & 364c n.16. The Tenth Circuit was similarly "suspicious" of Blue Cross' proconsumer arguments. Pet. App. at 38b n.22. In fact, the evidence before the jury formed a clear basis for its conclusion that Blue Cross' conduct would work to the detriment of Kansas consumers. Pet. App. at 38b.

Contrary to petitioners' argument, the result here does not threaten the establishment of legitimate PPO's. Blue Cross' conduct, if allowed to continue, would instead have had the effect of deterring PPO's and other innovative forms of health care financing in Kansas, and the jury so found. The result presents no conflict with any other circuit.

III. THERE IS NO REASON TO REVIEW AN *ALLEN* CHARGE IN A CIVIL CASE.

Finally, in a single closing paragraph, petitioners ask this Court to review the trial court's *Allen* charges.[6] Petitioners suggest only that the court below erred, not that this issue is one of national importance or the subject of a conflict among the circuits. But the court below did not err. The Tenth Circuit carefully analyzed circuit law governing *Allen* charges, and concluded that the district court's charges were proper. Pet. App. at 72b. It recognized that analyzing *Allen* charges requires "case-by-case [inquiry] to determine the coercive effect of the instruction." Pet. App. at 73b. There is no reason to grant certiorari to review the unique facts of the *Allen* charges in this non-criminal case.

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[6] The first three "questions presented" in the petition for certiorari are addressed in text. The fourth question presented—involving a Kansas state law issue that is only presented if petitioners win their antitrust arguments—should not require the attention of this Court. The fifth question presented, involving the grant of summary judgment on a counterclaim, presents neither a question of national importance nor a split among the circuits.

CONCLUSION

This case presents no conflict with decisions of this—or any other—court. The Court should deny the petition for certiorari.

Respectfully submitted,

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Dated: May 29, 1990